CHAPTER 9505

DEPARTMENT OF HUMAN SERVICES

HEALTH CARE PROGRAMS

MEDICAL ASSISTANCE ELIGIBILITY

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SURVEILLANCE AND INTEGRITY REVIEW PROGRAM

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MEDICAL ASSISTANCE ELIGIBILITY

9505.0010 APPLICABILITY.

Parts 9505.0010 to 9505.0140 govern the administration of the medical assistance program and establish the standards used to determine the eligibility of an individual to participate in the medical assistance program.

These parts must be read in conjunction with title XIX of the Social Security Act; Code of Federal Regulations, title 42; Minnesota Statutes, chapter 256B, and sections 256.01, subdivision 2, clauses (1) and (14), 256.01, subdivision 4, clause (4), 256.011, 256.045, and 256.98.

Statutory Authority: *MS s 256B.04*

History: *11 SR 1069*

Published Electronically: *January 14, 2010*

9505.0011 ADMINISTRATION.

Subpart 1. **Compliance with state and federal law.** The commissioner shall cooperate with the federal government in order to qualify for federal financial participation in the medical assistance program. All persons should be aware that parts 9505.0010 to 9505.0140 of the medical assistance program may be superseded by a change in state or federal law or by a court order prior to the agency having an opportunity to amend these rules.

Subp. 2. **Administrative relationships.** The medical assistance program is administered by local agencies under the supervision of the commissioner. The commissioner shall supervise the medical assistance program on a statewide basis so that local agencies comply with the standards of the program.

A local agency shall provide fair and equal treatment to an applicant or recipient according to statewide policies. The commissioner is authorized to correct a policy or practice that conflicts with statewide program requirements. A local agency shall comply with procedures and forms prescribed by the commissioner in bulletins and manuals insofar as they are consistent with parts 9505.0010 to 9505.0140.

Statutory Authority: *MS s 256B.04*

History: *11 SR 1069*

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9505.0015 DEFINITIONS.

Subpart 1. **Applicability.** For the purposes of parts 9505.0010 to 9505.0140, the following terms have the meanings given to them in this part.

Subp. 2. [Repealed, 26 SR 977]

Subp. 3. **Applicant.** "Applicant" means a person who submits a written application to the local agency for a determination of eligibility for medical assistance.

Subp. 4. **Application.** "Application" means the applicant's written request for medical assistance as provided in part 9505.0085.

Subp. 5. **Application date.** "Application date" means the day on which a local agency or a designated representative of the commissioner receives, during normal working hours, a written request for medical assistance consisting of at least the name of the applicant, a means to locate the applicant, and signature of the applicant, provided the completed application form required in part 9505.0085 is submitted to the local agency within 30 days of the written request.

Subp. 6. **Asset.** "Asset" means any property that is owned and has monetary value. Examples of assets are negotiable instruments including cash or bonds, real and personal property, and rights that a person has in tangible or intangible property.

Subp. 7. [Repealed, 26 SR 977]

Subp. 8. **Authorized representative.** "Authorized representative" means an individual authorized by the applicant or recipient to apply for medical assistance or perform duties required of the applicant or recipient by parts 9505.0010 to 9505.0140 on that person's behalf.

Subp. 9. **Commissioner.** "Commissioner" means the commissioner of human services or the commissioner's designated representative.

Subp. 10. [Repealed, 26 SR 977]

Subp. 11. **County of service.** "County of service" means the county where the applicant or recipient resides. However, if the applicant or recipient resides in a state hospital, the county of service is the county of financial responsibility.

Subp. 12. **Department.** "Department" means the Department of Human Services.

Subp. 13. **Earned income.** "Earned income" means wages, salary, commission, or other benefits received by a person as monetary compensation from employment or self-employment.

Subp. 14. **Eligibility factors.** "Eligibility factors" means all the conditions, limits, standards, and required actions in parts 9505.0010 to 9505.0120 that the applicant or recipient must satisfy in order to be eligible for medical assistance.

Subp. 15. [Repealed, 26 SR 977]

Subp. 16. **General assistance medical care or GAMC.** "General assistance medical care" or "GAMC" means the program established under Minnesota Statutes, section 256D.02, subdivision 4a.

Subp. 17. **Gross earned income.** "Gross earned income" means all earned income before any deduction, disregard, or exclusion.

Subp. 18. **Gross income.** "Gross income" means all earned and unearned income before any deduction, disregard, or exclusion.

Subp. 19. **Health maintenance organization.** "Health maintenance organization" means a corporation as defined in Minnesota Statutes, section 62D.02, subdivision 4.

Subp. 20. **Health services.** "Health services" means the services and supplies furnished to a recipient by a provider for a health related purpose as specified in Minnesota Statutes, sections 256B.02, subdivision 8 and 256B.0625.

Subp. 21. **Hospital.** "Hospital" means an acute care institution licensed under Minnesota Statutes, sections 144.50 to 144.58, defined in Minnesota Statutes, section 144.696, subdivision 3, and maintained primarily for the treatment and care of persons with disorders other than tuberculosis or mental diseases.

Subp. 22. **Income.** "Income" means cash or other benefits, whether earned or unearned, received by or available to an applicant or recipient and not determined to be an asset under parts 9505.0058 to 9505.0064 or part 9505.0065.

Subp. 23. **In-kind income.** "In-kind income" means a benefit other than cash that provides food, shelter, clothing, transportation, or health service and is not determined to be an asset under parts 9505.0058 to 9505.0064 or part 9505.0065.

Subp. 24. **Inpatient.** "Inpatient" means a person who has been admitted to an inpatient hospital and has not yet been formally discharged. Inpatient applies to a person absent from a hospital on a pass ordered by a physician. For purposes of this definition, a person absent from the hospital against medical advice is not an inpatient during the absence.

Subp. 25. **Life estate.** "Life estate" means an interest in real property with the right of use or enjoyment limited to the life or lives of one or more human beings that is not terminable at any fixed or computable period of time.

Subp. 26. [Repealed, 26 SR 977]

Subp. 27. **Local agency.** "Local agency" means a county or multicounty agency that is authorized under Minnesota Statutes, sections 393.01, subdivision 7 and 393.07, subdivision 2, as the agency

responsible for determining eligibility for the medical assistance program. "Local agency" is used in parts 9505.0010 to 9505.0140 to refer to the local agency of the county of service unless otherwise specified.

Subp. 28. **Long-term care facility.** "Long-term care facility" means a residential facility certified by the Minnesota Department of Health as a skilled nursing facility or as an intermediate care facility including an intermediate care facility for persons with developmental disabilities.

Subp. 29. [Repealed, 26 SR 977]

Subp. 30. [Repealed, 26 SR 977]

Subp. 31. **Medical assistance or MA.** "Medical assistance" or "MA" means the program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 32. **Medicare.** "Medicare" means the health insurance program for the aged and disabled under title XVIII of the Social Security Act.

Subp. 33. **Minnesota supplemental aid or MSA.** "Minnesota supplemental aid" or "MSA" means the program established under Minnesota Statutes, sections 256D.33 to 256D.54.

Subp. 34. **Net income.** "Net income" means the income remaining after applicable disregards, exclusions, and deductions are subtracted from gross income.

Subp. 35. [Repealed, 26 SR 977]

Subp. 36. **Parent.** "Parent" means the birth or adoptive mother or father of a child.

Subp. 37. **Person.** "Person" means an applicant or recipient of medical assistance.

Subp. 38. **Prior authorization.** "Prior authorization" means the written approval and issuance of an authorization number by the department to a provider before the provision of a covered health service, as specified in part 9505.5010.

Subp. 39. **Provider.** "Provider" means a vendor as specified in Minnesota Statutes, section 256B.02, subdivision 7, that has signed an agreement approved by the department for the provision of health services to a recipient.

Subp. 40. **Real property.** "Real property" means land and all buildings, structures, and improvements or other fixtures on it, all rights and privileges belonging or appertaining to it, all manufactured homes attached to it on permanent foundations, and all trees, mines, minerals, quarries, and fossils on or under it.

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

Subp. 42. **Residence.** "Residence" means the place a person uses, and intends to continue to use for the indefinite future, as his or her primary dwelling place.

Subp. 43. [Repealed, 26 SR 977]

Subp. 44. **Spenddown.** "Spenddown" means the process by which a person who has income in excess of the income standard allowed under part 9505.0065, subpart 1 becomes eligible for medical assistance as a result of incurring medical expenses that are not covered by a liable third party and that reduce the excess income to zero.

Subp. 45. **State medical review team.** "State medical review team" means those physicians and social workers who are under contract with the department to review a medical and social history to determine a person's disability within the scope of the regulations of the Social Security Administration.

Subp. 46. **Third-party payer.** "Third-party payer" refers to a person, entity, agency, or government program other than Medicare or the medical assistance program, that has a probable obligation to pay all or part of the costs of a recipient's health services. Examples are an insurance company, health maintenance organization, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), workers' compensation, and defendants in legal actions arising out of an accidental or intentional tort.

Subp. 47. **Title XIX state plan.** "Title XIX state plan" refers to the document submitted for approval to the Centers for Medicare and Medicaid Services defining the conditions of medical assistance program eligibility and services authorized by title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 48. **Unearned income.** "Unearned income" means income other than earned income as defined in subpart 13.

Subp. 49. **Wrongfully obtaining assistance.** "Wrongfully obtaining assistance" means:

A. action by an applicant or recipient of willfully or intentionally withholding, concealing, or misrepresenting information which results in a person's receipt of medical assistance in excess of the amount for which he or she is eligible under the program and the eligibility basis claimed by the applicant or recipient;

B. receipt of real or personal property by an individual without providing reasonable compensation and for the known purpose of creating an applicant's or recipient's eligibility for medical assistance; or

C. action by an individual of conspiring with or knowingly aiding or abetting an applicant or recipient to wrongfully obtain medical assistance.

Statutory Authority: *MS s 256B.04; L 2000 c 340 s 17*

History: *11 SR 1069; 12 SR 1148; L 1988 c 689 art 2 s 268; 26 SR 977; L 2002 c 277 s 32; L 2005 c 56 s 2*

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9505.0016 [Repealed, 26 SR 977]

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9505.0020 [Repealed, 26 SR 977]

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9505.0030 RESIDENCY REQUIREMENTS.

Subpart 1. **Minnesota residency required.** Eligibility for medical assistance is limited to Minnesota residents or persons presumed to be Minnesota residents under Code of Federal Regulations, title 42, section 435.403. A Minnesota resident is:

A. a person who establishes a residence in Minnesota during the month for which eligibility is considered and who is not eligible for or receiving medical assistance from another state;

B. a person who is determined to be a Minnesota resident under Code of Federal Regulations, title 42, section 435.403; or

C. a migrant worker as specified in Minnesota Statutes, section 256B.06, subdivision 3.

Subp. 2. [Repealed, 26 SR 977]

Subp. 3. [Repealed, 26 SR 977]

Statutory Authority: *MS s 256B.04; L 2000 c 340 s 17*

History: *11 SR 1069; 26 SR 977*

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9505.0040 [Repealed, 26 SR 977]

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9505.0044 [Repealed, 26 SR 977]

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9505.0045 RESIDENTS OF INSTITUTIONS FOR TREATMENT OF MENTAL DISEASES.

A resident of an institution for the treatment of mental diseases is eligible for medical assistance only if the resident is receiving inpatient psychiatric care in a psychiatric facility accredited by the joint commission on accreditation of hospitals, and meets one of the following conditions: is a person under 21 years of age; or a person 21 years of age but less than 22 years of age who has been receiving inpatient psychiatric care continuously since the resident's 21st birthday; or is a person at least 65 years of age. Notwithstanding the other provisions of parts 9505.0010 to 9505.0140, a person in an institution for the treatment of mental diseases who is over 21 years of age but less than 65 years of age is only eligible for health services before the date of admittance and after the date of discharge from an institution for the treatment of mental diseases. For purposes of this part, "institution for the treatment of mental diseases" means those facilities defined in Code of Federal Regulations, title 42, section 435.1009.

Statutory Authority: *MS s 256B.04*

History: *11 SR 1069; 26 SR 977*

Published Electronically: *August 12, 2008*

9505.0050 PERSONS DETAINED BY LAW.

A person, regardless of age, who is detained by law in the custody of a correctional or detention facility as a person accused or convicted of a crime is not eligible for medical assistance. A resident of a correctional facility who is furloughed by the corrections system to a medical facility for treatment or to a residential habilitation program or halfway house without a formal release on probation, parole, bail, his or her own recognizance, or completion of sentence or a finding of not guilty is not eligible for medical assistance.

A person admitted as an inpatient to a hospital on a hold order issued on a civil basis is not considered detained by law.

Statutory Authority: *MS s 256B.04*

History: *11 SR 1069*

Published Electronically: *August 12, 2008*

9505.0055 EFFECT OF PUBLIC ASSISTANCE STATUS ON MEDICAL ASSISTANCE ELIGIBILITY.

Subpart 1. [Repealed, 26 SR 977]

Subp. 2. [Repealed, 26 SR 977]

Subp. 3. [Repealed, 26 SR 977]

Subp. 4. [Repealed, 26 SR 977]

Subp. 5. **Child in foster care.** A child whose foster care is paid under title IV-E of the Social Security Act is eligible for medical assistance upon application and verification of foster care status.

Subp. 6. **Person receiving supplemental security income.** A person receiving supplemental security income must make a separate application for the medical assistance program except as in subpart 1.

Statutory Authority: *MS s 256B.04; L 2000 c 340 s 17*

History: *11 SR 1069; L 1994 c 631 s 31; 26 SR 977*

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9505.0058 [Repealed, 26 SR 977]

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9505.0059 [Repealed, 26 SR 977]

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9505.0061 [Repealed, 26 SR 977]

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9505.0062 [Repealed, 26 SR 977]

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9505.0063 [Repealed, 26 SR 977]

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9505.0064 [Repealed, 26 SR 977]

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9505.0065 INCOME.

Subpart 1. **Income eligibility standard.** Income becomes an asset if it is retained beyond the month in which it is received.

Subp. 2. [Repealed, 26 SR 977]

Subp. 3. [Repealed, 26 SR 977]

Subp. 4. [Repealed, 26 SR 977]

Subp. 5. [Repealed, 26 SR 977]

Subp. 6. [Repealed, 26 SR 977]

Subp. 7. [Repealed, 26 SR 977]

Subp. 8. [Repealed, 26 SR 977]

Subp. 9. [Repealed, 26 SR 977]

Subp. 10. [Repealed, 26 SR 977]

Subp. 11. [Repealed, 26 SR 977]

Subp. 12. [Repealed, 26 SR 977]

Statutory Authority: *MS s 252.28; 256B.04; 256B.092; 256B.503; L 2000 c 340 s 17*

History: *11 SR 1069; 12 SR 1148; L 1988 c 689 art 2 s 268; L 1994 c 631 s 31; 26 SR 977*

Published Electronically: *August 12, 2008*

9505.0070 THIRD-PARTY LIABILITY.

Subpart 1. **Definition.** For purposes of parts 9505.0070 and 9505.0071, "assignment" or "assignment of benefits" means the written authorization by a person, the person's authorized representative, a policyholder, or other authorized representative, to transfer to another individual, entity, or agency his or her right or the rights of his or her dependents to medical care support or other third-party payments.

Subp. 2. **Third-party payer; primary coverage.** A third-party payer who is liable to pay all or part of the cost of a health service provided to a medical assistance applicant or recipient shall be the primary payer. The third party payer's coverage of or liability for a health service provided to a medical assistance applicant or recipient must be used to the fullest extent available before a medical assistance payment is made on the recipient's behalf.

Subp. 3. **Provider responsibility to obtain information and assignment of benefits.** The provider shall obtain information about the recipient's potential health service coverage by a third party payer from the recipient, from the recipient's responsible relative, or from the remittance advice provided by the department upon rejection of a claim because of the department's identification of a potential third-party payer. Further, the provider may obtain an assignment of benefits from the recipient, policyholder, or other authorized individual or representative. In the case of a dependent child insured under a policy held by a parent or

other individual who does not have custody of the child, the provider may obtain the assignment from the individual who has custody of the child.

Subp. 4. **Provider billing; third party.** When a provider is informed by a recipient, the recipient's responsible relative or authorized representative, a local agency, or the department that the recipient has health service coverage by a third-party payer, the provider shall bill the third-party payer before seeking medical assistance payment for the health service.

Subp. 5. **Provider billing; department.** Except as in subpart 7, the provider shall not submit a claim for medical assistance payment until receiving from the third-party payer payment, partial payment, or notice that the claim has been denied. A provider may submit a claim for medical assistance payment for the difference between the amount paid by the third party and the amount payable by medical assistance in the absence of other coverage. However, no medical assistance payment will be made to a provider under contract with a private health coverage plan when the private health coverage plan calls for the provider to accept the plan's payment as payment in full. The provider who submits a claim for medical assistance payment by the department after a third-party payer has paid part of the claim or denied the claim shall submit with the claim the additional information or records required by the department to document the reason for the partial payment or denial.

Subp. 6. **Time limit for submission of claims.** A provider must submit claims to the department according to the 12-month billing requirement in part 9500.1080, subpart 2.

Subp. 7. **Provider billing; third party failure to respond.** A provider who has not received either a payment or denial notice from a third-party payer within 90 days after submitting the claim for payment may bill the medical assistance program. The provider shall submit to the department, no later than 12 months after the date of service to the recipient, a copy of the original claim to the third-party payer, documentation of two further attempts to contact the third-party payer, and any written communication the provider has received from the third-party payer.

Subp. 8. **Recovery of payments to recipients.** Notwithstanding part 9500.1080, subpart 1, a provider may bill a recipient to recover the amount of a payment received by a recipient from a third-party payer. The department is liable only to the extent that the amount payable by medical assistance exceeds the third-party liability.

Subp. 9. [Repealed, 26 SR 977]

Statutory Authority: *MS s 256B.04; L 2000 c 340 s 17*

History: *11 SR 1069; 26 SR 977*

Published Electronically: *August 12, 2008*

9505.0071 ASSIGNMENT OF RIGHTS.

Subpart 1. **Notification to local agency.** A person or the person's authorized representative shall notify the local agency of the availability of third-party payer coverage at the time of application, at the time of an eligibility redetermination, and within ten days of a change in potential coverage.

Subp. 2. **Assignment of benefits.** All legally able medical assistance applicants and recipients shall assign to the department their rights and the rights of their dependent children to benefits from liable or potentially liable third-party payers. An applicant or recipient who refuses to assign to the department his or her own rights or those of any other person for whom he or she can legally make an assignment is ineligible

for medical assistance. A person who is otherwise eligible for medical assistance shall not have his or her eligibility denied or delayed because he or she can not legally assign his or her own rights and the individual legally able to make the assignment refuses to assign the rights.

Subp. 3. [Repealed, 26 SR 977]

Subp. 4. [Repealed, 26 SR 977]

Subp. 5. **Good cause exemption.** Before requiring an individual to cooperate in obtaining medical care support or payments for other persons not covered by subpart 4, a local agency shall notify the individual that he or she may claim a good cause exemption from the requirements of subpart 3 at the time of application or at any subsequent time. When an individual submits a good cause claim in writing, the individual shall submit corroborative evidence of the good cause claims to the local agency within 20 days of submitting the claim. The local agency must send the claim and the corroborative evidence to the department and must stop action related to obtaining medical care support and payments.

A. Good cause exists when cooperation is against the best interests of the individual or other person to whom medical assistance is being furnished because it is anticipated that cooperation will result in reprisal against and cause physical or emotional harm to the individual or other person.

B. The local agency shall provide reasonable assistance to an individual who has difficulty getting the evidence to support a good cause claim. When a local agency or the department requires additional evidence to make a determination on the claim for good cause, the local agency or department shall notify the individual that additional evidence is required, explain why the additional evidence is required, identify what form this evidence might take, and specify an additional period that will be allowed to obtain it.

C. The department shall determine whether good cause exists based on the weight of the evidence.

D. When the department determines that good cause exists, the exemption from cooperation under subpart 3, must remain in effect for the period the person remains eligible under that application. A good cause exemption must be allowed under subsequent applications without additional evidence when the factors which led to the exemption continue to exist. A good cause exemption allowed under this subpart must end when the factors which led to allowing the exemption have changed.

E. When the department denies a claim for a good cause exemption and enforcement action resumes, the individual must submit additional evidence in support of any later claim for a good cause exemption before the department or local agency can again stop action to obtain medical care support or payments under subpart 3.

F. Following a determination that an individual has good cause for refusing to cooperate, a local agency and the department shall take no further action to obtain medical care support or payments until the good cause exemption ends under item D.

Statutory Authority: *MS s 256B.04; L 2000 c 340 s 17*

History: *11 SR 1069; 26 SR 977*

Published Electronically: *October 16, 2013*

9505.0075 Subpart 1. [Repealed, 26 SR 977]

Subp. 2. [Repealed, 26 SR 977]

Subp. 3. [Repealed, 26 SR 977]

Subp. 4. [Repealed, 16 SR 2780]

Subp. 5. [Repealed, 26 SR 977]

Subp. 6. [Repealed, 26 SR 977]

Subp. 7. [Repealed, 26 SR 977]

Subp. 8. [Repealed, 26 SR 977]

Subp. 9. [Repealed, 26 SR 977]

Subp. 10. [Repealed, 26 SR 977]

Published Electronically: *August 12, 2008*

9505.0080 COOPERATION WITH QUALITY CONTROL REVIEW.

Subpart 1. **Cooperation required.** A recipient, or the recipient's authorized representative or guardian, shall cooperate with the department's quality control review process by providing information necessary to verify the recipient's eligibility for medical assistance. In order to continue a recipient's eligibility, the recipient, representative, or guardian must:

A. agree to a personal interview with the quality control staff person at a mutually acceptable time and location; and

B. assist the quality control staff person in securing verifications necessary to establish eligibility for the month of review, provided verifications do not duplicate what is already in the case record and do not cause the recipient to incur an expense in securing those verifications.

Subp. 2. **Consequences of failure to cooperate.** Failure to cooperate with the quality control review process without good cause shall result in termination of assistance. A person has good cause under this subpart if the person's refusal to cooperate stems from a diagnosis of mental illness or a physical disability or illness long enough and severe enough to prevent the person from participating within the period the quality control unit has allotted to complete its review process.

Statutory Authority: *MS s 256B.04*

History: *11 SR 1069*

Published Electronically: *August 12, 2008*

9505.0085 RIGHT TO APPLY; MAKING APPLICATION.

Subpart 1. **Applying for medical assistance.** Any person or the person's authorized representative may apply for medical assistance at the local agency in the county of the person's residence, or in the county of the authorized representative's residence, or in the county of financial responsibility. The local agency that receives a request for medical assistance from an individual either by telephone or in person shall inform the individual of the eligibility factors and requirements and the procedure for making a written application. The local agency shall inform the individual that he or she has a right to apply for medical assistance, regardless of the agency's informal assessment as to the likely eligibility of the individual. The application must be completed by the applicant or the applicant's authorized representative, on the application form prescribed by the department. A local agency shall not require an individual to appear at the local agency for an interview

or to submit verification of eligibility factors before the date when the individual submits the completed application form. The local agency shall accept the application and provide the applicant with information about the eligibility factors. The date of the application shall be as defined in part 9505.0015, subpart 5. An applicant may apply for eligibility consideration of up to three calendar months prior to the month of application.

Subp. 2. **Application by authorized representative.** A person who is incapable of completing the application or providing the information and verifications required for the determination of eligibility for the medical assistance program may authorize a representative. If the person is incapable of authorizing a representative, another individual may assume authorized representative status if the individual has access to needed information, is able to verify eligibility factors, and agrees in writing to assume the responsibilities of the applicant and recipient as set forth in parts 9505.0070 to 9505.0130 and Minnesota Statutes, section 256B.08. The local agency has the right to remove an authorized representative who does not perform the required duties. If no qualified individual is available to act as authorized representative, the local agency shall appoint a social service professional to serve in that role.

Statutory Authority: *MS s 256B.04*

History: *11 SR 1069*

Published Electronically: *August 12, 2008*

9505.0090 LOCAL AGENCY ACTION ON APPLICATION.

Subpart 1. [Repealed, 26 SR 977]

Subp. 2. **Time limit for agency action.** The local agency shall act on an application for medical assistance no later than 45 days from the date of a medical assistance application on behalf of a person who is neither blind nor disabled. In the case of application on behalf of a blind or disabled person, the local agency shall complete the eligibility determination no later than 60 days from the date of the application. The local agency shall not construe the 45- or 60-day period for determination as a waiting period. The local agency must not deny an application earlier than the end of the 45- or 60-day period because of the applicant's refusal to provide the required information.

Subp. 3. **Required notice in case of delay.** If the information and documentation required by parts 9505.0010 to 9505.0140 are not obtained within the time limit, the local agency shall notify the applicant, in writing, about the deficiencies of the application, the reason for the delay in determining the applicant's eligibility, and the applicant's right to appeal the agency's delay of a decision under part 9505.0130.

If the reason for the delay is the applicant's refusal to provide required information or documentation, the agency's written notice to the applicant must also state that eligibility will be denied unless the applicant provides the information within ten days of the date of the notice to the applicant.

If the reason for the delay is the applicant's inability to obtain or provide the information, the agency shall assist the applicant to obtain the information.

When a delay results because necessary information cannot be obtained within the time limit, the local agency shall notify the applicant of the reason for the delay in writing, and of the applicant's right to appeal the delay.

Subp. 4. **Withdrawal of application.** An applicant may withdraw his or her application at any time by giving written or oral notice to the local agency. The local agency shall issue a written notice confirming

the withdrawal. The notice must inform the applicant of the local agency's understanding that the applicant has withdrawn the application and no longer wants to pursue it. When, within ten days of the date of the agency's notice, an applicant informs a local agency in writing that he or she does not want to withdraw the application, the local agency shall reinstate, and finish processing the application.

Statutory Authority: *MS s 256B.04; L 2000 c 340 s 17*

History: *11 SR 1069; 26 SR 977*

Published Electronically: *August 12, 2008*

9505.0095 VERIFICATION OF ELIGIBILITY INFORMATION.

The local agency shall verify the eligibility factors, in determining the medical assistance eligibility of the applicant. The local agency must not require an applicant or recipient to verify more than once an eligibility factor not subject to change and available in existing medical assistance files of the local agency.

The applicant shall provide all necessary information and documents and give the local agency written authorization to contact sources who are able to verify the required information to the local agency. An applicant who refuses to authorize verification of an eligibility factor including a social security number shall be denied medical assistance eligibility.

Statutory Authority: *MS s 256B.04*

History: *11 SR 1069*

Published Electronically: *August 12, 2008*

9505.0100 NOTICE OF AGENCY DECISION ON ELIGIBILITY.

The local agency must notify a person, in writing, in the format determined by the department, of the agency's decision on the person's medical assistance eligibility. The notice must be sent within the time limits set in part 9505.0090 and comply with the requirements of part 9505.0140. If the determination is to deny eligibility, the local agency shall give the person the reasons for the denial and state the person's right to appeal the denial as provided in part 9505.0130.

Statutory Authority: *MS s 256B.04*

History: *11 SR 1069*

Published Electronically: *August 12, 2008*

9505.0105 APPLICATION FOR STATE HOSPITAL RESIDENTS.

A state hospital resident may apply for medical assistance at the state hospital reimbursement office. The reimbursement office shall assist the hospital resident in completing the application form and shall forward the application to the local agency of the county of financial responsibility for the local agency's determination of eligibility. The date of the application is the date on which the state hospital reimbursement office receives a signed application. The local agency shall notify the reimbursement office of actions taken on the application, a delay in determining eligibility, and any change in eligibility status.

Statutory Authority: *MS s 256B.04*

History: *11 SR 1069*

Published Electronically: *August 12, 2008*

9505.0110 PERIODS OF ELIGIBILITY.

Subpart 1. **Retroactive eligibility.** Retroactive eligibility is available for the three calendar months before the month of application. Retroactive eligibility must be determined as if the applicant had applied in the retroactive month except for the reduction of excess assets. Retroactive eligibility is available on the date after the day on which excess assets are reduced. Retroactive eligibility does not depend on a finding of eligibility for the month of application or for all of the months in the retroactive period and is not limited to consecutive months in the retroactive period.

Subp. 2. [Repealed, 26 SR 977]

Subp. 3. **Eligibility for entire month.** A person who satisfies all eligibility requirements at any time within a month is eligible for the entire month beginning with the first of the month unless:

A. eligibility ends because the person dies;

B. the starting date is delayed by an income spenddown requirement;

C. the starting date of retroactive eligibility begins as specified under subpart 1; or

D. federal law limits the beginning date of eligibility to another date.

Statutory Authority: *MS s 256B.04; L 2000 c 340 s 17*

History: *11 SR 1069; 26 SR 977*

Published Electronically: *October 16, 2013*

9505.0115 REDETERMINATION OF ELIGIBILITY.

Subpart 1. **Report of change.** An applicant or recipient must report a change in an eligibility factor to the local agency within ten days of learning about the change.

Subp. 2. **Redetermination after change in eligibility factor.** The local agency shall redetermine eligibility if a change in an eligibility factor is reported.

Subp. 3. [Repealed, 26 SR 977]

Subp. 4. **Redetermination for state hospital resident.** The local agency of the county of financial responsibility may request the state hospital reimbursement officer to obtain the information necessary for the local agency to redetermine the state hospital resident's medical assistance eligibility.

Subp. 5. [Repealed, 26 SR 977]

Statutory Authority: *MS s 256B.04; L 2000 c 340 s 17*

History: *11 SR 1069; 14 SR 2632; 26 SR 977*

Published Electronically: *August 12, 2008*

9505.0120 [Repealed, 26 SR 977]

Published Electronically: *August 12, 2008*

9505.0125 NOTICE OF DENIAL OR TERMINATION.

Subpart 1. **Notice to applicant or recipient.** The local agency or department shall send the person a written notice, in the format prescribed by the department, when the agency or department denies prior authorization, restricts free choice of provider, or reduces services, or reduces, denies, or terminates the person's medical assistance eligibility. The notice must clearly state the proposed action, the reason for the action, the person's right to appeal the proposed action, and the person's right to reapply for eligibility or additional eligibility. The notice must comply with parts 9505.0100 and 9505.0140. Except as in subpart 2, the notice must be sent as specified in items A to C:

A. In the case of restriction of free choice of provider or reduction of services, the notice must be sent by the department to the person no later than ten days before the effective date of the restriction or reduction.

B. In the case of denial of prior authorization, the department shall notify the recipient and the provider no later than 30 working days after receipt of all information required for prior authorization.

C. In the case of a denial, reduction, or termination of eligibility, the local agency shall notify the person no later than ten calendar days before the effective date of the action. Except in the case of the recipient's death, the effective date of the termination is the first day of the month after the month in which the recipient no longer met the eligibility factors. In the case of a recipient's death, the effective date of termination is the day after the date of the recipient's death.

Subp. 2. **Exceptions to period of notice.** The circumstances in items A and B permit exceptions to the period of notice required in subpart 1:

A. The period of notice may be five days before the date of the proposed action if the local agency has facts indicating probable fraud by the applicant or recipient and if the facts have been verified through a secondary source.

B. The agency may mail a notice not later than the date of action if:

(1) The local agency has facts confirming the death of an applicant or recipient. The effective date of the notice is the day after the date of death.

(2) The local agency receives a written statement from the applicant or recipient that he or she no longer wants to receive medical assistance.

(3) The recipient has been admitted to a penal facility, or an institution for the treatment of mental diseases where he or she is ineligible for further health services.

(4) The local agency verifies that another state has determined that the applicant or recipient is eligible for medical assistance.

Statutory Authority: *MS s 256B.04*

History: *11 SR 1069*

Published Electronically: *August 12, 2008*

9505.0130 RIGHT TO APPEAL; APPEAL PROCESS.

Subpart 1. **Rights of applicant or recipient.** An applicant or recipient of medical assistance has the right to a hearing:

A. if the local agency fails to act on the application within required time limits;

B. if eligibility is denied or terminated;

C. if the recipient's spend down is increased;

D. if the recipient's choice of provider is restricted;

E. if payment for a health insurance premium is denied because the department determines the insurance policy is not cost-effective for the medical assistance program; and

F. if the department denies a recipient's request for health service.

A local agency shall not reduce, suspend, or terminate eligibility when a recipient appeals under subpart 2 before the later of the effective date of the action or within ten days of the agency's mailing of the notice unless the recipient requests in writing not to receive continued medical assistance while the appeal is pending.

Subp. 2. **Appeal process.** An applicant or recipient may appeal the proposed action within 30 days after the notice was sent to the applicant or recipient by the local agency. The appeal must be filed within 30 days of the local agency's action. However, a delay to 90 days is allowed if an appeals referee finds that the applicant has good cause for failing to request a hearing within 30 days. The applicant's or recipient's written appeal and request for hearing must be submitted to the department by the local agency. A state appeals referee shall conduct a hearing and recommend to the commissioner a course of action in the case. The commissioner shall issue an order affirming, reversing, or modifying the action or decision of the local agency or the department. This order is binding upon the local agency and the aggrieved party unless an appeal is filed with the district court within 30 days of the commissioner's order, under Minnesota Statutes, section 256.045, subdivision 7.

Subp. 3. [Repealed, 26 SR 977]

Subp. 4. **Right to review records.** A local agency shall allow a person, the person's authorized representative, or the person's guardian to review the records that the local agency maintains concerning the person's medical assistance application and eligibility, except for records to which access is denied under Minnesota Statutes, chapter 13. A local agency shall make the records available to the person, the person's authorized representative, or the person's guardian as soon as possible but no later than the fifth business day after the date of the request. When a person, the person's authorized representative, or the person's guardian asks for photocopies of material from the person's records, the local agency shall provide one copy of each page at no cost to the individual making the request.

Statutory Authority: *MS s 256B.04; L 2000 c 340 s 17*

History: *11 SR 1069; 26 SR 977*

Published Electronically: *August 13, 2013*

9505.0131 WRONGFULLY OBTAINED ASSISTANCE.

Subpart 1. **Applicability to other laws.** This part outlines procedures that apply to medical assistance eligibility and are available for use in combination with established civil and criminal procedures and law.

Subp. 2. **Responsibility of local agency to act.** A local agency that receives an allegation of a person wrongfully obtaining assistance shall take any or all of the actions in items A to C.

A. The local agency shall refer a case involving a person suspected of wrongfully obtaining assistance to the person or unit designated by the board of commissioners in the county of the local agency for investigation of the suspected fraud.

B. The local agency shall issue notice according to part 9505.0125 to reduce or terminate the person's medical assistance eligibility when the local agency receives facts and, if possible, verifies the facts that show a person is not eligible for medical assistance or for the amount currently being received.

C. If the preliminary investigation gives the local agency reason to believe that fraud has occurred, the local agency shall refer cases involving persons suspected of wrongfully obtaining assistance to the county attorney.

Subp. 3. **Continued medical assistance eligibility.** A local agency shall continue medical assistance eligibility if current program eligibility exists even when wrongfully obtained medical assistance was proven for an earlier period or is under current investigation as in subpart 2.

Subp. 4. **Recovery of wrongfully obtained medical assistance.** A local agency shall recover or attempt to recover wrongfully obtained medical assistance. The amount recovered must not be more than the amount wrongfully obtained unless the amount is based on a court judgment. A local agency shall seek voluntary repayment or initiate civil court proceedings to recover the balance of the wrongfully obtained assistance that has not been repaid.

Subp. 5. **Reporting requirement.** A local agency shall gather and report statistical data required by the commissioner on local agency activities to prevent persons from wrongfully obtaining medical assistance.

Statutory Authority: *MS s 256B.04*

History: *11 SR 1069*

Published Electronically: *August 12, 2008*

9505.0135 ADMINISTRATIVE FUNCTIONS OF LOCAL AGENCY.

Subpart 1. **Local agency responsibility.** The local agency is responsible for the medical assistance program and shall determine eligibility for the program under the supervision of the department as provided in Minnesota Statutes, section 256B.05.

Subp. 2. **Submittal of information.** The local agency shall submit to the department information about applicants and recipients in the form prescribed by the department.

Subp. 3. **Maintenance of records.** The local agency shall develop and maintain accurate records regarding implementation of parts 9505.0010 to 9505.0140. The local agency shall keep the records in a way that complies with the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13. The records must contain a central register of the names of all persons who apply for medical assistance.

Subp. 4. **Estate claims.** The local agency of the county of financial responsibility shall file claims against the estates of medical assistance recipients as provided in Minnesota Statutes, section 256B.15. The county of financial responsibility shall receive 50 percent of the nonfederal share of estate claim recoveries.

Subp. 5. [Repealed, 26 SR 977]

Subp. 6. [Repealed, 26 SR 977]

Statutory Authority: *MS s 256B.04; L 2000 c 340 s 17*

History: *11 SR 1069; 26 SR 977*

Published Electronically: *August 12, 2008*

9505.0140 PAYMENT FOR ACCESS TO MEDICALLY NECESSARY SERVICES.

Subpart 1. **Access to medically necessary services.** The local agency shall ensure that a service listed in items A to C is available to a medical assistance recipient to enable the recipient to obtain a medically necessary health service. The local agency shall pay directly for these services and may charge them to the medical assistance program administrative account for reimbursement. The services are:

A. Sign language interpreter, if a person who is deaf, deafblind, or hard-of-hearing must have an interpreter in order to receive health services from a provider with fewer than 15 employees.

B. Transportation by volunteer driver, common carrier, or contract for service, or direct mileage reimbursement to the recipient or the recipient's driver. The mileage reimbursement must be at the rate specified in part 9505.0065, subpart 5, item D. Parking fees must be reimbursed at actual cost.

C. Meals and lodging necessary to obtain health services. Direct payment or reimbursement to a vendor or to the recipient for the cost of the recipient's meals and lodging necessary to obtain health services eligible for medical assistance reimbursement must be the lesser of the actual cost of the lodging and meals or the standard for lodging and meals established under Minnesota Statutes, section 43A.18, subdivision 2.

D. Meals, lodging, and transportation costs of a responsible relative or other person to accompany or be present with the recipient at the site of health services. When a responsible relative or another individual is needed to accompany the recipient or to be present with the recipient at the site of a health service medically necessary for the recipient, the accompanying individual must be reimbursed for the cost of his or her meals, transportation, and lodging based on the standard for the recipient.

Subp. 2. **Local agency procedure to ensure access.** By March 22, 1987, and every two years after, the local agency shall submit to the department a transportation plan that specifies the means the local agency will use to meet the requirements of subpart 1. The department shall review the plan and advise the local agency whether it meets the requirements of subpart 1. The local agency shall inform a recipient of the county's transportation plan. A local agency may require prior approval of the payments of costs in subpart 1 if exceptions are made for emergencies and retroactive eligibility.

Subp. 3. **Local agency procedure to ensure access to hearings.** A local agency shall reimburse applicants and recipients for reasonable and necessary expenses of their attendance at hearings held pursuant to part 9505.0130, subpart 1, such as child care and transportation costs.

Statutory Authority: *MS s 256B.04*

History: *11 SR 1069; L 2013 c 62 s 32*

Published Electronically: *August 1, 2013*

9505.0145 [Repealed, 26 SR 977]

Published Electronically: *August 12, 2008*

9505.0150 [Repealed, 26 SR 977]

Published Electronically: *August 12, 2008*

MEDICAL ASSISTANCE PAYMENTS

9505.0170 APPLICABILITY.

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

Parts 9505.0170 to 9505.0475 must be read in conjunction with title XIX of the Social Security Act for appropriate populations; title XXI of the Social Security Act for appropriate populations; Code of Federal Regulations, title 42; Minnesota Statutes, including chapters 256 and 256B; and parts 9505.5000 to 9505.5105.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 36 SR 10*

Published Electronically: *August 22, 2011*

9505.0175 DEFINITIONS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subp. 17. **Inpatient.** "Inpatient" means a person who has been admitted to an inpatient hospital and has not yet been formally discharged. Inpatient applies to a person absent from a hospital on a pass ordered by a physician. For purposes of this definition, a person absent from the hospital against medical advice is not an inpatient during the absence.

Subp. 18. [Repealed, 35 SR 1967]

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

Subp. 20. [Repealed, 35 SR 1967]

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

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

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

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

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

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

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

C. is a preventive health service under part 9505.0355.

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

Subp. 27. **Mental health practitioner.** "Mental health practitioner" means a person who is qualified as specified in Minnesota Statutes, section 245.4871, subdivision 26, to serve a person under age 21, or who is qualified as specified in Minnesota Statutes, section 245.462, subdivision 17, to serve a person at least age 21.

Subp. 28. **Mental health professional.** "Mental health professional" means a person who provides clinical services in the treatment of mental illness of an adult and who is qualified in at least one of the ways specified in Minnesota Statutes, section 245.462, subdivision 18, clauses (1) to (4), or a person who provides clinical services in the treatment of the emotional disturbance of a child and is qualified in at least one of the ways specified in Minnesota Statutes, section 245.4871, subdivision 27, clauses (1) to (4), or in the manner specified in the state Medicaid plan and who receives clinical supervision as specified in part 9505.0323, subpart 31.

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

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

Subp. 31. **On the premises.** "On the premises," when used to refer to a person supervising the provision of the health service, means that the person is physically located within the clinic, long-term care facility, or the department within the hospital where services are being provided at the time the health service is provided.

Subp. 32. [Repealed, L 2015 c 78 art 5 s 5]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subp. 46. **Supervision.** "Supervision," 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.

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

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

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

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

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.

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

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

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

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

Statutory Authority: *MS s 245.461 to 245.486; 256B.04; 256B.0625*

History: *12 SR 624; L 1988 c 689 art 2 s 268; 13 SR 1439; 14 SR 8; 17 SR 1454; 17 SR 2042; 21 SR 525; L 2005 c 56 s 2; 35 SR 1967; L 2015 c 78 art 5 s 5*

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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: *12 SR 624; 15 SR 2563*

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9505.0185 [Repealed, 30 SR 1318]

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9505.0190 RECIPIENT CHOICE OF PROVIDER.

Subject to the limitations in Minnesota Statutes, section 256B.69, and in parts 9505.2160 to 9505.2245, a recipient who requires a medically necessary health service may choose to use any provider located within Minnesota or within the recipient's local trade area. No provider other than a prepaid health plan shall require a recipient to use a health service that restricts a recipient's free choice of provider. A recipient who enrolls in a prepaid health plan that is a provider must use the prepaid health plan for the health services provided under the contract between the prepaid health plan and the department.

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 12, 2008*

9505.0195 PROVIDER PARTICIPATION.

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

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

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

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

D. monitor and enforce the vendor's compliance with parts 9505.2160 to 9505.2245 and with the terms of the provider agreement.

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

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

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

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

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

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

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

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

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

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

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

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

Subp. 6. **Consequences of failure to comply.** A provider who fails to comply with the terms of participation in the provider agreement or parts 9505.0170 to 9505.0475 or 9505.2160 to 9505.2245 is subject to monetary recovery, sanctions, or civil or criminal action as provided in parts 9505.2160 to 9505.2245. Unless otherwise provided by law, no provider of health services shall be declared ineligible without prior notice and an opportunity for a hearing under Minnesota Statutes, chapter 14, on the commissioner's proposed action.

Subp. 7. **Vendor who is not a provider.** A vendor of health services who does not have a provider agreement in effect, but who provides health services to recipients and who otherwise receives payments from the medical assistance program, is subject to parts 9505.0170 to 9505.0475 and 9505.2160 to 9505.2245.

Subp. 8. **Sale or transfer of entity providing health services.** A provider who sells an entity which has been enrolled to provide medical assistance services or who transfers ownership or control of an entity that has been enrolled to provide medical assistance services shall notify the department of the sale or transfer no later than 30 days before the effective date of the sale or transfer. The purchaser or transferee shall notify the department of transfer or sale no later than the effective date of the sale or transfer. Nothing in this subpart shall be construed to limit the right of the department to pursue monetary recovery or civil or criminal action against the seller or transferor as provided in parts 9505.2160 to 9505.2245.

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

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

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

C. obtain department approval as in subpart 3; and

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *December 2, 2013*

9505.0200 COMPETITIVE BIDDING.

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

A. the projected fiscal year savings of medical assistance funds, resulting from purchase of the item through the bidding procedure, exceeds the cost of administering the competitive bidding procedure. The projected savings in a fiscal year must be computed by determining the difference between actual expenditures for the item in the previous fiscal year and an estimated expenditure based on the actual number of units purchased times the predicted competitive bid prices; or

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 13, 2013*

9505.0205 PROVIDER RECORDS.

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 12, 2008*

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*

Published Electronically: *August 13, 2013*

9505.0215 COVERED SERVICES; OUT-OF-STATE PROVIDERS.

Subpart 1. **Out-of-state provider.** For purposes of this part, "out-of-state provider" means a provider who is located outside of Minnesota and outside of the recipient's local trade area.

Subp. 2. **Reimbursement requirements.** A health service provided to a recipient by an out-of-state provider is eligible for medical assistance payment if the service meets the requirements of items A, B, and C.

A. The service must be a covered service as defined in part 9505.0175, subpart 6.

B. The provider must obtain prior authorization if prior authorization is required under Minnesota Statutes, section 256B.0625, subdivision 25, parts 9505.0170 to 9505.0475, or parts 9505.5000 to 9505.5030.

C. The service must meet one of the following conditions:

(1) the department determines, on the basis of medical advice from a consultant as defined in part 9505.5005, subpart 3, that the service is not available in Minnesota or the recipient's local trade area;

(2) the service is in response to an emergency; or

(3) the service is needed because the recipient's health would be endangered if the recipient was required to return to Minnesota.

Subp. 3. **Inapplicability when recipient not out-of-state.** The requirements in subpart 2, item C, do not apply when, at the time of service, the recipient is located within Minnesota or the recipient's local trade area.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 17 SR 3047; 36 SR 10*

Published Electronically: *August 22, 2011*

9505.0220 HEALTH SERVICES NOT COVERED BY MEDICAL ASSISTANCE.

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

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

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

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

D. autopsies;

E. missed or canceled appointments;

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

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

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

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

J. separate charges for the preparation of bills;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Statutory Authority: *MS s 256B.04*

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

Published Electronically: *August 12, 2008*

9505.0221 PAYMENT LIMITATION; PARTIES AFFILIATED WITH A PROVIDER.

Except as allowed in part 9505.0287, equipment, supplies, or services prescribed or ordered by a physician are not eligible for medical assistance payment if they are provided:

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 17 SR 2042*

Published Electronically: *August 12, 2008*

9505.0225 REQUEST TO RECIPIENT TO PAY.

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 12, 2008*

9505.0235 ABORTION SERVICES.

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

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

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

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

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

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

48 hours after its occurrence, the report must be made within 48 hours after the victim becomes physically able to report the criminal sexual conduct.

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 12, 2008*

9505.0240 AMBULATORY SURGICAL CENTERS.

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

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

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

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

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

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

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

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

F. Blood, blood plasma, and platelets.

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 12, 2008*

9505.0245 CHIROPRACTIC SERVICES.

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

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

B. "Chiropractor" means a person licensed under Minnesota Statutes, sections 148.01 to 148.108.

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

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

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

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

A. laboratory service;

B. diathermy;

C. vitamins;

D. ultrasound treatment;

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

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

G. x-rays not listed in subpart 2.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *January 14, 2010*

9505.0250 CLINIC SERVICES.

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

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

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

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 12, 2008*

9505.0255 COMMUNITY HEALTH CLINIC SERVICES.

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

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

B. has tax exempt status as provided in Internal Revenue Code, section 501(c)(3) as amended through October 4, 1976, or is established as a hospital authority under Minnesota Statutes, section 144.581, or is operated under the control of the commissioner under Minnesota Statutes, section 246.01; and

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

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

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

A. physician services under part 9505.0345;

B. preventive health services under part 9505.0355;

C. family planning services under part 9505.0280;

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

E. dental services under part 9505.0270; and

F. prenatal care services under part 9505.0353.

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

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

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 15 SR 910; L 1989 c 304 s 137*

Published Electronically: *August 12, 2008*

9505.0260 COMMUNITY MENTAL HEALTH CENTER SERVICES.

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

A. "Community mental health center service" means services by a community mental health center that provides mental health services specified in part 9505.0371, subpart 2, and physician services under part 9505.0345, including the determination of a need for prescribed drugs and the evaluation of prescribed drugs.

B. Notwithstanding the definition of "supervision" in part 9505.0175, subpart 46, "supervision" means "clinical supervision" as defined in part 9505.0370, subpart 6.

C. For purposes of this part, "mental health professional" means a "mental health professional" as defined in part 9505.0175, subpart 28 and a person licensed in marriage and family therapy under Minnesota Statutes, sections 148B.29 to 148B.39 and employed by a provider of community mental health center services.

Subp. 2. **Eligible providers of community mental health center services.** To be eligible to enroll in the medical assistance program as a provider of community mental health center services, a provider must:

A. be established as specified in Minnesota Statutes, section 245.62;

B. obtain the commissioner's approval according to Minnesota Statutes, section 245.69, subdivision 2;

C. be a private, nonprofit corporation or a public agency;

D. have a board of directors established under Minnesota Statutes, section 245.66;

E. be operated by or under contract with a local agency to provide community mental health services;

F. comply with parts 9520.0750 to 9520.0870 and other parts of chapter 9520 applicable to community mental health centers;

G. provide mental health services as specified in Minnesota Statutes, section 245.62, subdivision 4;

H. provide mental health services specified in Minnesota Statutes, sections 245.461 to 245.4887;

I. have a sliding fee schedule; and

J. if providing services to persons with alcohol and other drug problems, be licensed to provide outpatient treatment under parts 9530.5000 to 9530.6500.

Subp. 3. **Payment limitation; community mental health center services.** Medical assistance payment limitations applicable to community mental health center services include the payment limitations in parts 9505.0370 to 9505.0372.

Subp. 4. [Repealed, 17 SR 1454]

Subp. 5. **Excluded services.** The services listed in part 9505.0372, subpart 11, are not eligible for medical assistance payment as community mental health services.

Statutory Authority: *MS s 245.484; 256B.04; 256B.0625*

History: *14 SR 8; 17 SR 1454; L 2003 1Sp14 art 11 s 11; 35 SR 1967*

Published Electronically: *July 5, 2011*

9505.0270 DENTAL SERVICES.

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

A. "Crown" means a restoration covering or replacing the major part or the whole portion of the tooth not covered by supporting tissues.

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

C. "Fixed partial denture" or "fixed cast metal restoration" or "fixed bridge" means a prosthetic replacement of one or more missing teeth that is cemented or attached to the abutment adjacent to the space filled by the prosthetic replacement and that cannot be removed by the patient.

D. "Implant" means material inserted or grafted into tissue or bone; or a device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement.

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

F. "Rebase" means the process of refitting a denture by replacing the base material.

G. "Reline" means the process of resurfacing the tissue side of the denture with a new base material.

H. "Removable prosthesis" or "removable dental prosthesis" includes dentures and removable partial dentures and means any dental device or appliance replacing one or more missing teeth, including associated structures, if required, that is designed to be removed and reinserted by the patient.

Subp. 2. **Covered dental services.** A covered dental service is any dental service that meets the general requirements for MA-covered services in part 9505.0210, subject to the limits in this part and the requirements in parts 9505.5010 and 9505.5030 that apply when prior authorization is a condition of payment. Services that require authorization are published in the State Register as required by Minnesota Statutes, section 256B.0625, subdivision 25. The list of services requiring authorization is continuously updated in the Minnesota Health Care Program (MHCP) providers' manual issued by the Minnesota Department of Human Services and is incorporated by reference. The manual is available on line at www.dhs.state.mn.us under the bulletins, publications, and manuals selection. The Web site may be accessed through a computer at a public library. The services in items A to S indicate the scope of covered services but are not an exclusive or exhaustive list of covered services. When individual medical need requires a service that is not listed in this subpart, a provider has the option of seeking prior authorization for the service under parts 9505.5010 and 9505.5030 unless the service is an excluded dental service under subpart 10.

A. oral hygiene instruction;

B. fluoride treatment;

C. panoramic film;

D. dental x-rays;

E. dental prophylaxis;

F. sealants;

G. oral evaluation;

H. full mouth debridement;

I. behavior management, which in dental terminology, is a documented service that is necessary to ensure that a covered dental procedure is performed correctly and safely;

J. space maintainer;

K. oral surgery and extractions;

L. fillings;

M. endodontic therapy and periodontic therapy;

N. removable partial dentures;

O. removable dentures;

P. crowns that meet the specifications in subpart 2a, item G;

Q. orthodontic treatment that meets the specifications in subpart 2a, item F;

R. reline or rebase of a removable denture; and

S. dental implants that meet the criteria in subpart 2a, item H.

Subp. 2a. **Payment limits on covered dental services.** Payment for some of the covered dental services listed in subpart 2 is limited as specified in items A to H.

A. Initial placement or replacement of a removable prosthesis is limited to once every three years per patient unless a condition in subitem (1) or (2) applies:

(1) Replacement of a removable prosthesis in excess of the limit in item A is eligible for payment if the replacement is necessary because the removable prosthesis was misplaced, stolen, or damaged due to circumstances beyond the patient's control. When applicable, the patient's degree of physical and mental impairment must be considered in determining whether the circumstances were beyond a patient's control.

(2) Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's dental needs.

B. Service for a removable prosthesis must include instruction in the use and care of the prosthesis and any adjustment necessary to achieve a proper fit during the six months immediately following the provision of the prosthesis. The dentist shall document the instruction and the necessary adjustments, if any, in the patient's dental record.

C. All criteria under subitems (1) to (3) must be met in order for a provider to receive payment for a cast metal removable prosthesis:

(1) the crown to root ratio must be better than 1:1;

(2) the surrounding abutment teeth and the remaining teeth must not have extensive tooth decay; and

(3) the abutment teeth must not have large restorations or stainless steel crowns.

D. The criteria in subitems (1) to (4) must be met in order to receive payment for periodontal scaling and root planing:

(1) evidence of bone loss must be present on the current radiographs - panoramic, full mouth series or bitewing - to support the diagnosis of periodontitis;

(2) there must be current periodontal charting with six point and mobility noted, including the presence of pathology and periodontal prognosis;

(3) the pocket depths must be greater than four millimeters; and

(4) classification of the periodontology case type must be in accordance with documentation established by the American Academy of Periodontology.

E. Hospitalization coverage for dental surgeries and services is subject to parts 9505.0501 to 9505.0545, which establish a system for reviewing the use of inpatient hospital services.

F. At least one of the following criteria must be met in order to receive payment for orthodontic treatment:

(1) there is a disfigurement of the patient's facial appearance including protrusion of upper or lower jaws or teeth;

(2) there is spacing between adjacent teeth which interferes with the biting function;

(3) there is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when the person bites;

(4) positioning of jaws or teeth impairs chewing or biting function; or

(5) based on a comparable assessment of subitems (1) to (4), there is an overall orthodontic problem that interferes with the biting function.

G. Except as medically necessary in conjunction with a fixed bridge covered by this part or an implant covered by this part, an individual crown must be made of prefabricated stainless steel, prefabricated resin, or laboratory resin in order to be covered.

H. The criteria in subitems (1) to (3) must be met in order to receive payment for dental implants and related services:

(1) there must be bone and tooth loss that compromises chewing or breathing;

(2) the implants must be medically necessary and cost-effective; and

(3) a complete treatment plan, including prosthesis and all related services, must be approved prior to the start of treatment.

Subp. 3. [Repealed, 26 SR 1630]

Subp. 4. [Repealed, 26 SR 1630]

Subp. 5. [Repealed, 26 SR 1630]

Subp. 6. [Repealed, 26 SR 1630]

Subp. 7. [Repealed, 26 SR 1630]

Subp. 8. [Repealed, 26 SR 1630]

Subp. 9. [Repealed, 26 SR 1630]

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

A. pulp caps;

B. a local anesthetic that is used in conjunction with an operative or surgical procedure and billed as a separate procedure;

C. hygiene aids, including toothbrushes;

D. medication dispensed by a dentist that a patient is able to obtain from a pharmacy;

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

F. prosthesis cleaning;

G. removable unilateral partial denture that is a one-piece cast metal including clasps and teeth;

H. dental services for cosmetic or aesthetic purposes;

I. fixed partial denture or fixed bridge, unless it has been determined to be medically necessary and cost-effective for a patient who cannot use a removable prosthesis due to a mental or physical medical condition;

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

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

L. implants and related services when the conditions and criteria in subpart 2a, item H, are not met.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 26 SR 1630*

Published Electronically: *August 12, 2008*

9505.0275 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT.

Subpart 1. **Definition.** "Early and periodic screening, diagnosis, and treatment service" means a service provided to a recipient under age 21 to identify a potentially disabling condition and to provide diagnosis and treatment for a condition identified according to the requirements of the Code of Federal Regulations, title 42, section 441.55 and parts 9505.1693 to 9505.1748.

Subp. 2. **Duties of provider.** The provider shall sign a provider agreement stating that the provider will provide screening services according to standards in parts 9505.1693 to 9505.1748 and Code of Federal Regulations, title 42, sections 441.50 to 441.62.

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

History: *12 SR 624; 13 SR 1150; L 2005 c 56 s 2*

Published Electronically: *August 12, 2008*

9505.0277 EYEGLASS SERVICES.

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

A. "Comprehensive vision examination" means a complete evaluation of the visual system.

B. "Dispensing services" means the technical services necessary for the design, fitting, and maintenance of eyeglasses as prescribed by an optometrist or ophthalmologist.

C. "Eyeglass services" means comprehensive and intermediate vision examinations provided by and within the scope of practice of a provider who is an optometrist or ophthalmologist and the eyeglasses provided by an optician, optometrist, or ophthalmologist.

D. "Eyeglasses" means a pair of lenses mounted in a frame and other aids to vision prescribed by an optometrist or ophthalmologist.

E. "Intermediate vision examination" means an evaluation of a specific visual problem.

F. "Medically necessary eyeglasses" means that:

(1) for initial eyeglasses, there is a correction of .50 diopters or greater in either sphere or cylinder power in either eye; or

(2) for a change in eyeglasses, there is a change in correction of .50 diopters or greater in either sphere or cylinder power in either eye, or a shift in axis of greater than ten degrees in either eye. For purposes of this item, "diopter" means the unit of refracting power of the lens.

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

H. "Optician" means a supplier of eyeglasses to a recipient as prescribed by the recipient's optometrist or ophthalmologist.

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

Subp. 2. **Covered eyeglass services.** The eyeglass services in items A to E are eligible for medical assistance payment.

A. Comprehensive vision examinations.

B. Intermediate vision examinations.

C. An initial pair of medically necessary eyeglasses.

D. A pair of eyeglasses that are an identical replacement of a pair of eyeglasses that was misplaced, stolen, or irreparably damaged.

E. A new pair of eyeglasses due to a change in the recipient's head size, a change in vision after a comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary, or an allergic reaction to the eyeglass frame material. For purposes of this part, "change in eyeglasses" means a change in prescription.

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

A. Services provided for cosmetic reasons. Examples are:

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

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

B. Dispensing services related to noncovered services.

C. Fashion tints and polarized lenses, unless medically necessary.

D. Protective coating for plastic lenses.

E. Edge and antireflective coating of lenses.

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

G. Eyeglasses, lenses, or frames that are not medically necessary.

H. Invisible bifocals or progressive bifocals.

I. An eyeglass service for which a required prior authorization was not obtained.

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

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

L. Repair of eyeglasses during the warranty period if the repair is covered by warranty.

M. Purchase of eyeglasses or lenses not covered by a contract obtained through the competitive bidding process under part 9505.0200.

N. Backup eyeglasses.

O. Photochromatic lenses except for a person who has a diagnosis of albinism, achromatopsia, aniridia, blue cone monochromatism, cystinosis, or retinitis pigmentosa, or any other condition for which such lenses are medically necessary.

P. Transition lenses.

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

History: *19 SR 2004*

Published Electronically: *August 12, 2008*

9505.0280 FAMILY PLANNING SERVICES.

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

A. "Family planning service" means a family planning supply or health service, including screening, testing, and counseling for sexually transmitted diseases, such as HIV, when provided in conjunction with the voluntary planning of the conception and bearing of children and related to a recipient's condition of fertility.

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

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

A. the recipient requested the service;

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

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 22 SR 1592*

Published Electronically: *August 12, 2008*

9505.0285 HEALTH CARE PREPAYMENT PLANS OR PREPAID HEALTH PLANS.

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

A. have a contract with the department; and

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 12, 2008*

9505.0287 HEARING AID SERVICES.

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

A. "Audiologic evaluation" means an assessment of communication problems caused by hearing loss that is performed by an audiologist or an otolaryngologist.

B. "Audiologist" has the meaning given in part 9505.0390, subpart 1, item A.

C. "Hearing aid" means a monaural hearing aid, a set of binaural hearing aids, or other device worn by the recipient to improve the recipient's access to and use of auditory information.

D. "Hearing aid accessory" means chest harnesses, tone and ear hooks, carrying cases, and other accessories that are not included in the cost of the hearing aid but that are necessary to the recipient's use of the hearing aid.

E. "Hearing aid services provider" means:

(1) a person who has a certificate from the commissioner of health as a dispenser of hearing instruments as specified in Minnesota Statutes, chapter 153A;

(2) an audiologist;

(3) an otolaryngologist; or

(4) a provider, as specified in part 9505.0175, subpart 38, who employs dispensers of hearing instruments, audiologists, or otolaryngologists.

A hearing aid services provider who is not an audiologist or an otolaryngologist must not perform an audiologic evaluation.

F. "Hearing aid services" means the services provided by a hearing aid services provider that are necessary to dispense hearing aids and provide hearing aid accessories and repairs.

G. "Otolaryngologist" means a physician specializing in diseases of the ear and larynx who is board eligible or board certified by the American Board of Otolaryngology.

Subp. 2. **Covered hearing aid services.** To be eligible for medical assistance payment, the hearing aid services must meet the requirements of items A to E and the other requirements of this part.

A. A physician's examination must determine that the recipient does not have medical or surgical conditions that contraindicate fitting the recipient with a hearing aid.

B. The physician who examines the recipient must refer the recipient for an audiologic evaluation to determine if the recipient has a communication disorder caused by a hearing loss and if a hearing aid is medically necessary for the recipient.

C. The audiologist or otolaryngologist who conducts the audiologic evaluation required under item B must order a specific hearing aid based on the findings of the audiologic evaluation.

D. The hearing aid services provider must provide the hearing aid that is recommended by the audiologist or otolaryngologist.

E. The audiologist or otolaryngologist must inform the recipient of the need to schedule a follow-up visit and must request that the recipient schedule a follow-up visit to determine the effectiveness of the hearing aid within 30 days of providing the aid or within the time period specified in the contract obtained through the competitive bidding process under part 9505.0200, whichever is longer.

Subp. 3. **Eligibility for replacement hearing aid.** A recipient is not eligible to receive a replacement hearing aid through medical assistance within five years after a hearing aid was provided to the recipient under subpart 2 unless prior authorization is obtained from the commissioner. The criteria for prior authorization of a replacement hearing aid are listed in items A and B:

A. the recipient's present hearing aid is no longer effective because the recipient has had an increase in hearing loss; or

B. the recipient's hearing aid has been misplaced, stolen, or damaged due to circumstances beyond the recipient's control so that it cannot be repaired. The recipient's degree of physical and mental impairment must be considered in determining whether the circumstances were beyond the recipient's control. If the recipient's hearing aid was misplaced, stolen, or irreparably damaged more than two times in a five-year period, a recipient must not receive a replacement hearing aid.

Subp. 4. **Condition for payment; availability of hearing aid through contract purchase.** If the department seeks competitive bids under part 9505.0200 for the provision of hearing aids and if at least one of the hearing aids available to a recipient is consistent with the results of the audiologic evaluation, then medical assistance payment for the recipient's hearing aid is limited to a hearing aid available under part 9505.0200.

Subp. 5. **Hearing aid services provider payment.** A hearing aid services provider must receive one payment for fitting a new hearing aid for a recipient plus providing at least three batteries of the type necessary to operate the hearing aid. A hearing aid services provider must not request payment until after the hearing aid is dispensed. The payment also covers the following hearing aid services during the hearing aid warranty period:

A. instructing and counseling the recipient on the use and care of the hearing aid;

B. providing the recipient a copy of the manufacturer's warranty applicable to the recipient's hearing aid; and

C. returning the hearing aid to the manufacturer for repair.

Subp. 6. **Replacement batteries.** Medical assistance payment is available to pay for replacement batteries only in the quantity necessary to operate the hearing aid for a period of not more than 90 days, beginning with the date the hearing aid is provided to the recipient.

Subp. 7. **Hearing aid services to resident of long-term care facility.** For a resident of a long-term care facility to be eligible for medical assistance payment, the resident's hearing aid services must result from:

A. a request by the recipient;

B. a referral by a registered nurse, licensed practical nurse, or consulting nurse who is employed by the long-term care facility; or

C. a referral by the recipient's family, guardian, or attending physician.

For purposes of this subpart, "long-term care facility" means a residential facility certified by the Department of Health as a nursing facility or an intermediate care facility for the developmentally disabled.

Subp. 8. **Other covered hearing aid services.** Medical assistance payment is also available to pay for the hearing aid services in items A and B:

A. ear molds if the ear molds are not provided by the manufacturer as part of the hearing aid under the contract with the state, or if the earmolds are not customarily provided with the hearing aid; and

B. hearing aid accessories.

Subp. 9. **Trial period for audiologist's or otolaryngologist's evaluation of hearing aid.**

A. A hearing aid services provider must allow a recipient at least a 30-day trial or the period required by the contract between the state and the hearing aid manufacturer, whichever is longer, to allow an audiologist or otolaryngologist to determine whether the hearing aid meets the recipient's needs. The trial period consists of consecutive days beginning with the date the hearing aid is provided to the recipient. The hearing aid services provider must tell the recipient of the beginning and ending dates of the trial period.

B. If the audiologist or otolaryngologist determines that the hearing aid does not meet the recipient's needs, the audiologist or otolaryngologist must tell the recipient of the availability of further audiologic services as set forth in part 9505.0390, subpart 4, and order any necessary changes during the trial period.

Subp. 10. **Hearing aid services not covered.** Medical assistance payment is not available to pay for the following hearing aid services:

A. a hearing aid that is not medically necessary for the recipient;

B. replacement batteries, other than as specified in subpart 6, provided regardless of the recipient's need;

C. charges for picking up and delivering a hearing aid that are billed on a separate claim for payment;

D. repairs to a hearing aid during the warranty period and other hearing aid services that the contract between the state and the hearing aid manufacturer specifies must be provided within the contract price;

E. purchase without prior authorization of a hearing aid not covered by a contract obtained through the competitive bidding process under part 9505.0200;

F. hearing aid services billed on a separate claim for payment when the payment for the service is included in the dispensing fee for the hearing aid;

G. hearing aid drying kits, battery chargers, swim molds, or adapters for telephones, television, or radio;

H. canal hearing aids;

I. routine cleaning, checking, and other maintenance of hearing aids without request or referral from the recipient, the recipient's family, guardian, or attending physician; and

J. hearing aids prescribed or hearing aid services ordered by a physician if the hearing aids or the hearing aid services are provided by a person or entity that commits a felony listed in United States Code, title 42, section 1320a-7b, subject to the exceptions listed in Code of Federal Regulations, title 42, part 1001, section 952.

Statutory Authority: *MS s 256B.04*

History: *17 SR 2042; L 2005 c 56 s 2; 34 SR 537*

Published Electronically: *November 12, 2009*

9505.0290 HOME HEALTH AGENCY SERVICES.

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

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

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

A. Nursing service as defined by Minnesota Statutes, section 148.171, subdivision 15.

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

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

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 15 SR 2404; L 1999 c 172 s 18*

Published Electronically: *August 12, 2008*

9505.0295 HOME HEALTH SERVICES.

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

A. ordered by a physician; and

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

C. provided to the recipient at his or her residence that is a place other than a hospital or long-term care facility except as in part 9505.0360, or unless the home health service in an intermediate care

facility is for an episode of acute illness and is not a required standard for care, safety, and sanitation in an intermediate care facility under Code of Federal Regulations, title 42, part 442, subpart F or G.

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

A. nursing services under part 9505.0290;

B. home care nursing services under part 9505.0360;

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

D. personal care services under part 9505.0335;

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

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

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

H. oxygen ordered in writing by a physician.

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

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

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

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

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

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

(3) Home health services may be provided for a ventilator dependent recipient if the screening team determines the recipient's health care needs can be provided in the recipient's residence and the cost of home health services is less than the projected monthly cost of services provided by the least expensive hospital in the recipient's local trade area that is staffed and equipped to provide the recipient's necessary care. The recipient's physician in consultation with the staff of the hospital shall determine whether the hospital is staffed and equipped to provide the recipient's necessary care. The hospital's projected monthly cost must be computed by multiplying the projected monthly charges that the hospital would bill to medical assistance for services to the recipient by the hospital's cost to charge ratio as determined by a medical assistance settlement made under title XIX of the Social Security Act.

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

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 13 SR 1448; 15 SR 2404; L 2005 c 56 s 2; L 2014 c 291 art 9 s 5*

Published Electronically: *August 12, 2014*

9505.0297 HOSPICE CARE SERVICES.

Subpart 1. **Applicability.** Parts 9505.0297 and 9505.0446 must be read in conjunction with United States Code, title 42, section 1396a, and Code of Federal Regulations, title 42, part 418.

Subp. 2. **Definitions.** For purposes of this part and part 9505.0446, the following terms have the meanings given them.

A. "Business days" means every day except Saturday, Sunday, and legal holidays in Minnesota.

B. "Cap amount" means the limit on overall hospice reimbursement provided by part 9505.0446, subpart 4, and Code of Federal Regulations, title 42, sections 418.308 and 418.309, as amended through October 1, 1987.

C. "Employee" means an employee of the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice unit. Employee also includes a volunteer under the supervision of the hospice.

D. "Home" means the recipient's place of residence.

E. "Hospice" has the meaning given to hospice program in Minnesota Statutes, section 144A.48, subdivision 1, clause (4).

F. "Hospice care" means the services provided by a hospice to a terminally ill recipient under this part.

G. "Inpatient care" means the services provided by an inpatient facility to a recipient who has been admitted to a hospital, long-term care facility, or facility of a hospice that provides care 24 hours a day.

H. "Inpatient facility" means a hospital, long-term care facility, or facility of a hospice that provides care 24 hours a day.

I. "Interdisciplinary group" has the meaning given to interdisciplinary team in Minnesota Statutes, section 144A.48, subdivision 1, clause (5).

J. "Palliative care" has the meaning given in Minnesota Statutes, section 144A.48, subdivision 1, clause (6).

K. "Representative" means a person who, because of the terminally ill recipient's mental or physical incapacity, may execute or revoke an election of hospice care on behalf of the recipient under Minnesota law.

L. "Respite care" means short-term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient.

M. "Social worker" means a person who has at least a bachelor's degree in social work from a program accredited or approved by the Council of Social Work Education and who complies with Minnesota Statutes, sections 148B.21 to 148B.289.

N. "Terminally ill" means that the recipient has a medical prognosis that life expectancy is six months or less.

Subp. 3. **Provider eligibility.** A provider of hospice services is eligible for medical assistance payments if the provider is:

A. licensed or registered as a hospice under Minnesota Statutes, section 144A.48 or 144A.49; and

B. certified as a provider of hospice services under Medicare, in accordance with title XVIII of the Social Security Act, and Code of Federal Regulations, title 42, part 418.

Subp. 4. **Recipient eligibility.** To be eligible for medical assistance coverage of hospice care, a recipient must be certified as being terminally ill in the manner required by subpart 5.

Subp. 5. **Certification of terminal illness.** Within two calendar days after hospice care is initiated, the hospice must obtain written statements certifying that the recipient is terminally ill, signed by:

A. the medical director of the hospice or the physician member of the hospice's interdisciplinary group; and

B. the recipient's attending physician, if the recipient has one.

Within two calendar days after the recipient's first 90 days of hospice care and within two calendar days after the beginning of each subsequent 90-day period, the hospice must obtain a written statement certifying that the recipient is terminally ill, signed by the medical director of the hospice or the physician member of the hospice's interdisciplinary group.

Subp. 6. **Election of hospice care.** A recipient who is eligible for hospice care under subpart 4 and elects to receive hospice care, must submit an election statement to the hospice. The statement must include:

A. designation of the hospice that will provide care;

B. the recipient's acknowledgment that the recipient fully understands that the hospice provides palliative care rather than curative care with respect to the recipient's terminal illness;

C. the recipient's acknowledgment that the services under subpart 9 are waived by the election;

D. the effective date of the election, which must be no earlier than the date that the election is signed; and

E. the recipient's signature.

Subp. 7. **Election by representative.** A representative of the recipient may make the election and sign and submit the election statement to the hospice for the recipient according to subpart 6.

Subp. 8. **Notification of the election.** The hospice must mail or deliver a copy of the election statement required by subpart 6 to the local agency of the recipient's county of service, as defined by part 9505.0015, subpart 27, within two business days after the date the hospice receives the signed election statement.

Subp. 9. **Waiver of other benefits.** A recipient who elects hospice care under subpart 6 or for whom a representative elects hospice care under subpart 7 waives the right to medical assistance payments during the recipient's hospice stay for the following services:

A. Hospice care provided by a hospice other than the hospice designated by the recipient or the recipient's representative, unless the care is provided under arrangements made by the designated hospice.

B. Health services related to treatment of the terminal illness for which hospice care was elected or a condition related to the terminal illness, or services that are equivalent to hospice care, except for services:

(1) provided by the designated hospice;

(2) provided by another hospice under arrangements made by the designated hospice; and

(3) provided by the recipient's attending physician if that physician is not employed by the designated hospice or receiving compensation from the hospice for those services.

C. Personal care services, under part 9505.0335.

Subp. 10. **Duration of hospice services.** A recipient may receive hospice care until the recipient revokes the election under subpart 11 or no longer is eligible for hospice care under subpart 4.

Subp. 11. **Revoking the election.** A recipient or the recipient's representative may revoke the election of medical assistance coverage of hospice care at any time. To revoke the election, the recipient or representative must submit a statement to the hospice that includes:

A. a signed statement that the recipient or representative revokes the recipient's election of medical assistance coverage of hospice care; and

B. the date that the revocation is to be effective, which must be no earlier than the date on which the revocation is signed.

Subp. 12. **Notification of revocation.** The hospice must mail or deliver a copy of the revocation statement submitted under subpart 11 to the local agency of the recipient's county of service, as defined by part 9505.0015, subpart 27, within two business days after the date that the hospice receives the signed statement revoking the election.

Subp. 13. **Effect of revocation.** A recipient, upon revoking the election of medical assistance coverage of hospice care under subpart 11:

A. is no longer covered under medical assistance for hospice care;

B. resumes medical assistance coverage of the benefits waived under subpart 9; and

C. may elect to receive medical assistance coverage of hospice care at a later time, if eligible under this part at that time.

Subp. 14. **Change of hospice.** A recipient or the recipient's representative may change the designation of the hospice from which the recipient will receive hospice care. The change of the designated hospice is not a revocation of the election of medical assistance coverage of hospice care. To change the designation of the hospice, the recipient or the recipient's representative must submit both to the hospice where care has been received and to the newly designated hospice a signed statement that includes the following information:

A. the name of the hospice where the recipient has received care and the name of the hospice from which the recipient plans to receive care; and

B. the date the change is to be effective.

Subp. 15. **Requirements for medical assistance payment.** To be eligible for medical assistance coverage, hospice care must be:

A. reasonable and necessary for the palliation or management of the terminal illness and conditions related to the terminal illness;

B. in compliance with Minnesota Statutes, sections 144A.43 to 144A.49, and with the rules adopted under Minnesota Statutes, section 144A.48; and

C. consistent with the recipient's plan of care, established by the hospice.

Subp. 16. **Covered services.** As required by the recipient's plan of care, the services listed in items A to D must be provided directly by hospice employees, except that the hospice may contract for these services under the circumstances provided for in Code of Federal Regulations, title 42, section 418.80. As required by the recipient's plan of care, the services listed in items E to I must be provided directly or be made available by the hospice.

A. Nursing services provided by or under the supervision of a registered nurse.

B. Medical social services provided by a social worker under the direction of a physician.

C. Services performed by a physician, dentist, optometrist, or chiropractor.

D. Counseling services provided to the terminally ill recipient and the family members or other persons caring for the recipient at the recipient's home. Counseling, including dietary counseling, may be provided both to train the recipient's family or other caregiver to provide care, and to help the recipient and those caring for the recipient adjust to the recipient's approaching death.

E. Inpatient care, including procedures necessary for pain control or acute or chronic symptom management provided in a Medicare or medical assistance certified hospital, skilled nursing facility, or hospice unit that provides inpatient care. Inpatient care must conform to the written plan of care. A hospice that provides inpatient care must meet the standards in Code of Federal Regulations, title 42, sections 418.100(a) and (f), as amended through October 1, 1987.

F. Inpatient care, as a means of providing respite for the recipient's family or other persons caring for the recipient at home, provided in a Medicare or medical assistance certified hospital, skilled nursing facility, or hospice unit that provides inpatient care, or in a medical assistance certified intermediate care facility, subject to subpart 18.

G. Medical equipment and supplies, including drugs. Only drugs approved by the commissioner under part 9505.0340, subpart 3, item A, and used primarily to relieve pain and control symptoms of the recipient's terminal illness are covered. Medical equipment includes durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the recipient's terminal illness. Medical equipment must be provided by the hospice for use in the recipient's home while the recipient is under hospice care. Medical supplies include those specified in the written plan of care.

H. Home health aide services and homemaker services. Home health aides may provide personal care services as described in part 9505.0335, subparts 8 and 9. Home health aides and homemakers may perform household services to maintain a safe and sanitary environment in areas of the home used by the recipient, such as changing the recipient's bed linens or light cleaning and laundering essential to the comfort and cleanliness of the recipient. Home health aide services must be provided under the supervision of a registered nurse.

I. Physical therapy, occupational therapy, and speech-language pathology services provided to control symptoms or to enable the recipient to maintain activities of daily living and basic functional skills.

Subp. 17. **Services provided during a crisis.** A hospice may provide nursing services, including homemaker or home health aide services, to a recipient on a continuous basis for as much as 24 hours a day during a crisis as necessary to maintain a recipient at home. More than half of the care during the crisis must be nursing care provided by a registered nurse or licensed practical nurse. A crisis is a period in which the recipient requires continuous care for palliation or management of acute medical symptoms.

Subp. 18. **Respite care.** A hospice may provide respite care to a recipient only on an occasional basis and may not be paid for more than five consecutive days of respite care at a time. A hospice shall not provide respite care to a recipient who resides in a long-term care facility.

Subp. 19. **Bereavement counseling.** Bereavement counseling services must be made available by the hospice to the recipient's family until one year after the recipient's death. For purposes of this subpart, family includes persons related to the recipient or those considered by the recipient to be family because of their close association.

Subp. 20. **Medical assistance payment for hospice care.** Medical assistance shall be paid to a hospice for covered services according to part 9505.0446.

Statutory Authority: *MS s 256B.02*

History: *13 SR 1861; L 1997 c 193 s 47*

Published Electronically: *August 12, 2008*

9505.0300 INPATIENT HOSPITAL SERVICES.

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

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

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

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

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

Subp. 3. **Payment limitation.** Payment for inpatient hospital services to a recipient shall be made according to parts 9500.1090 to 9500.1140. Inpatient hospital services that are medically necessary for treatment of the recipient's condition are not eligible for a separate payment but are included within the payment rate established under parts 9500.1090 to 9500.1155. An example of a medically necessary service is a private room that the recipient's physician certifies as medically necessary.

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

Subp. 5. **Excluded services.** Inpatient hospital admission and services are not eligible for payment under the medical assistance program if they are not medically necessary under parts 9505.0501 to 9505.0545; if they are for alcohol detoxification that is not medically necessary to treat an emergency; if they are denied a required prior authorization; or if they are surgical procedures requiring a second surgical opinion that has failed to be approved by a second or third surgical opinion.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *January 14, 2010*

9505.0305 LABORATORY AND X-RAY SERVICES.

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

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 12, 2008*

9505.0310 MEDICAL SUPPLIES AND EQUIPMENT.

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

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

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

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

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

A. A provider who furnishes durable medical equipment for a recipient who is a resident of a hospital or long-term care facility may submit a separate claim for medical assistance payment if the equipment has been modified for the recipient or the item is necessary for the continuous care and exclusive use of the recipient to meet the recipient's unusual medical need according to the written order of a physician.

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

Payment for durable medical equipment that is not for the continuous care and exclusive use of the recipient is included within the payment rate made to the hospital under parts 9500.1090 to 9500.1140 and to the long-term care facility under part 9549.0060.

B. In addition to the types of equipment and supplies specified in Minnesota Statutes, section 256B.441, subdivision 11, the following durable medical equipment, prosthetics, and medical supplies are considered to be included in the payment to a hospital or long-term care facility and are not eligible for medical assistance payment on a separate claim for payment.

(1) Equipment of the type required under parts 4655.0090 to 4655.9342.

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

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

(4) Emergency oxygen.

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

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

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

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

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

C. maintenance of durable medical equipment.

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

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

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

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

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

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

E. dental hygiene supplies and equipment; and

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; L 2014 c 262 art 5 s 6*

Published Electronically: *October 21, 2014*

9505.0315 MEDICAL TRANSPORTATION.

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

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

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

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

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

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

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

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

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

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

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

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

C. Claims for payment for transportation between two long-term care facilities or between two hospitals must be documented by a statement signed by a member of the nursing staff at the originating facility that the medically necessary health service is part of the recipient's plan of care and is not available at the originating facility.

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

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

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

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

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

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

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

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

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

E. airport surcharge; and

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

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

A. The provider must be licensed under Minnesota Statutes, sections 144E.10 and 144E.16 as an advanced life support, basic life support, or scheduled ambulance service.

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

C. The medical necessity of the ambulance service for a recipient must be documented by the state report required under Minnesota Statutes, section 144E.17.

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

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

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

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

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

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

D. [Repealed, L 2013 c 81 s 12]

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; L 1987 c 209 s 39; L 1988 c 689 art 2 s 268; L 1997 c 199 s 14; L 2005 c 56 s 2; L 2013 c 81 s 12*

Published Electronically: *October 16, 2013*

9505.0320 NURSE MIDWIFE SERVICES.

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

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

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 12, 2008*

9505.0322 MENTAL HEALTH CASE MANAGEMENT SERVICES.

Subpart 1. **Definitions.** The terms used in this part have the meanings given them in items A to G and in part 9505.0370.

A. "Clinical supervision" has the meaning given in Minnesota Statutes, section 245.462, subdivision 4a, for case management services to an adult, or section 245.4871, subdivision 7, for case management services to a child.

B. "Face-to-face" means the recipient is physically present with the case manager.

C. "Mental health case management service" or "case management service" means a service that assists a person eligible for medical assistance in gaining access to needed medical, social, educational, and other services necessary to meet the person's mental health needs and that coordinates and monitors the delivery of these needed services.

D. For purposes of this part, "recipient" means a person who has been determined by the local agency to be eligible for the medical assistance program, who has a serious and persistent mental illness or severe emotional disturbance as determined by a diagnostic assessment, and who has been determined eligible for case management services by the local agency.

E. "Serious and persistent mental illness" means the condition of an adult as specified in Minnesota Statutes, section 245.462, subdivision 20, paragraph (c).

F. "Severe emotional disturbance" means the condition of a child as specified in Minnesota Statutes, section 245.4871, subdivision 6.

G. "Updating" or "updated" has the meaning given in Minnesota Statutes, section 245.467, subdivision 2, for an adult, or section 245.4876, subdivision 2, for a child.

Subp. 2. **Determination of eligibility to receive case management services.** The local agency must determine whether a person is eligible for case management services. The determination must be based on a diagnostic assessment of the person as a person with a serious and persistent mental illness or a severe emotional disturbance or on a determination according to subpart 4.

Subp. 3. **Required contents of a diagnostic assessment.** To be eligible for medical assistance payment, the diagnostic assessment required for a determination of a recipient's eligibility to receive mental health case management services must comply with the requirements of parts 9505.0370 to 9505.0372. Additionally, the diagnostic assessment must identify the needs that must be addressed in the recipient's individual treatment plan if the recipient is determined to have a serious and persistent mental illness or a severe emotional disturbance.

Subp. 4. **Eligibility if person does not have a current diagnostic assessment.** Medical assistance payment is available for case management services provided to a medical assistance eligible person who does not have a current diagnostic assessment if all of the following criteria are met:

A. the person requests or is referred for and accepts case management services;

B. the diagnostic assessment is refused at the time of the person's referral or request for case management services by:

(1) an adult for reasons related to the adult's mental illness;

(2) a child for reasons related to the child's emotional disturbance who meets a criterion specified in part 9505.0371, subpart 6; or

(3) the parent of a child;

C. the case manager determines that the person is eligible for case management services; and

D. the person obtains a new or updated diagnostic assessment within four months of the day the person first receives case management services.

Subp. 5. **Determination of recipient's continued eligibility for case management services.** A recipient's continued eligibility for case management services under this part and parts 9520.0900 to 9520.0926 must be determined every 36 months by the local agency. The determination of whether the recipient continues to have a diagnosis of serious and persistent mental illness or severe emotional disturbance must be based on updating the recipient's diagnostic assessment or on the results of conducting a complete diagnostic assessment because the recipient's mental health status or behavior has changed markedly. Unless a recipient's mental health status or behavior has changed markedly since the recipient's most recent diagnostic assessment, only updating is necessary. If the recipient's mental health status or behavior has changed markedly, a new diagnostic assessment must be completed.

Subp. 6. **Eligible provider of case management services.** A local agency, or an entity under contract to a local agency to provide case management services, is eligible to enroll as a provider of case management services.

Subp. 7. **Condition to receive medical assistance payment; case manager qualifications.** To be eligible for medical assistance payment, a case management service must be provided by a case manager who is qualified under Minnesota Statutes, section 245.462, subdivision 4, for services to an adult, or section 245.4871, subdivision 4, for services to a child.

Subp. 8. **Condition to receive medical assistance payment; clinical supervision required.** To be eligible for medical assistance payment for a case management service provided to a recipient by a mental health practitioner, the mental health practitioner must receive clinical supervision according to the requirements of Minnesota Statutes, section 245.462, subdivision 4a, for an adult, or section 245.4871, subdivision 7, for a child.

Subp. 9. **Case management services eligible for medical assistance payment.** Case management services provided to a recipient that are eligible for medical assistance payment are:

A. face-to-face contact between the case manager and the recipient;

B. telephone contact between the case manager and the recipient; the recipient's mental health provider or other service providers; the recipient's family members, legal representative, or primary caregiver; or other interested persons;

C. face-to-face contacts between the case manager and the recipient's family, legal representative, or primary caregiver; mental health providers or other service providers; or other interested persons;

D. contacts between the case manager and the case manager's clinical supervisor about the recipient;

E. individual community support plan and assessment development, review, and revision required under Minnesota Statutes, section 245.4711, subdivision 4, for an adult, or section 245.4881, subdivision 4, for a child;

F. travel time spent by the case manager to meet face-to-face with the recipient who resides outside of the county of financial responsibility; and

G. travel time spent by the case manager within the county of financial responsibility to meet face-to-face with the recipient or the recipient's family, legal representative, or primary caregiver.

For purposes of items F and G, if a case manager arrives on time for a scheduled face-to-face appointment with a recipient, the recipient's family, legal representative, or primary caregiver and the person fails to keep the appointment, the time spent by the case manager in traveling to and from the site of the scheduled appointment is eligible for medical assistance payment.

Subp. 10. **Limitation on payments for services.** Payment for case management services shall be limited according to items A to G.

A. Payment for case management services is limited to no more than ten hours per recipient per month, excluding time required for out-of-county travel under subpart 9, item F. The payment may be for any combination of the services specified in subpart 9, except that payment for telephone contact between a case manager and the recipient; the recipient's family, legal representative, or primary caregiver; mental health provider and other service providers; or other interested persons is limited to no more than three hours per recipient per month.

B. When traveling with a recipient, a case manager may not bill concurrently for both a face-to-face session with the recipient and travel time.

C. An assessment that duplicates an assessment eligible for payment under subpart 2 or 5 is not eligible for medical assistance payment.

D. Payment for case management services to a recipient is limited to the services of one case manager per unit of time per recipient.

E. Time spent by the case manager in charting and record keeping is not eligible for separate medical assistance payment as a case management service.

F. Time spent by the case manager in court during which the case manager is not providing a case management service that would otherwise be eligible for medical assistance payment is not a covered service.

G. Time spent in communication with other case managers who are members of the recipient's case management team under part 9520.0916 or 9520.0917 is not a covered service unless the recipient is a face-to-face participant in the communication.

Subp. 11. **Documentation of services.** To obtain medical assistance payment for case management services, the case manager must document the recipient's case management services according to the requirements of parts 9505.2175 and 9505.2180. Additionally, if a case manager who provides other mental health services eligible for medical assistance payment to a recipient who receives case management services from the case manager and intersperses the recipient's case management service and the other mental health services eligible for medical assistance payment within the same session, the case manager must clearly document in the recipient's record the intervals in which each service was provided.

Subp. 12. **Recovery of payment.** Medical assistance payments received by a case management provider for case management services that are not documented as required in subpart 11 are subject to recovery under parts 9505.2160 to 9505.2245.

Subp. 13. **Excluded service.** Client outreach for the purpose of seeking persons who potentially may be eligible for medical assistance and mental health case management services under this part is not eligible for medical assistance payment.

Subp. 14. **Coordination of case management services with other programs.** Case management services to recipients receiving case management services through a program other than medical assistance shall be coordinated as specified in items A to D.

A. Recipients who are receiving case management services through the Veterans Administration are not eligible for case management services under parts 9520.0900 to 9520.0926 and this part while they are receiving case management through the Veterans Administration.

B. Persons receiving home and community-based services under a waiver are not eligible for case management services under parts 9520.0900 to 9520.0926 and this part if these services duplicate each other. For purposes of this subpart, "home and community-based services under a waiver" refers to services furnished under a waiver obtained by the state from the United States Department of Health and Human Services as specified in Code of Federal Regulations, title 42, sections 440.180 and 441.300 to 441.310.

C. Except as provided in subpart 2, if a recipient has the diagnosis of developmental disability and the diagnosis of mental illness or emotional disturbance, the county shall assign the recipient a case manager for services to persons with developmental disability according to parts 9525.0015 to 9525.0165 and shall notify the recipient of the availability of case management services under parts 9520.0900 to 9520.0926. If the adult or the adult's legal representative or, in the case of a child, the child's parent or legal representative or, if appropriate, the child chooses case management services under parts 9520.0900 to 9520.0926, the case manager assigned under parts 9525.0015 to 9525.0165 and the case manager chosen under parts 9520.0900 to 9520.0926 shall work together as a team to ensure that the person receives services required under parts 9520.0900 to 9520.0926 and 9525.0015 to 9525.0165. The case manager under parts 9520.0900 to 9520.0926 shall be responsible for assuring that the requirements of parts 9520.0900 to 9520.0926 and 9525.0015 to 9525.0165 are met.

D. A recipient who has been assessed as chemically dependent under parts 9530.6615 and 9530.6620 and who also is determined to have a serious and persistent mental illness or a severe emotional disturbance is eligible to receive case management services under parts 9520.0900 to 9520.0926 and this part. The case manager assigned under parts 9520.0900 to 9520.0926 must coordinate the recipient's case management services with any similar services the person is receiving from other sources.

E. For purposes of this part, a recipient enrolled with a prepaid health plan under a prepaid medical assistance plan established under Minnesota Statutes, section 256B.031, is eligible for case management services as specified in this part on a fee-for-service basis from a provider other than the prepaid health plan.

Statutory Authority: *MS s 245.484; 256B.04; 256B.0625*

History: *17 SR 1454; L 2005 c 56 s 2; 35 SR 1967*

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9505.0323 Subpart 1. [Repealed, 35 SR 1967]

Subp. 2. [Repealed, 35 SR 1967]

Subp. 3. [Repealed, 35 SR 1967]

Subp. 4. [Repealed, 35 SR 1967]

Subp. 5. [Repealed, 35 SR 1967]

Subp. 6. [Repealed, 35 SR 1967]

Subp. 7. [Repealed, 35 SR 1967]

Subp. 8. [Repealed, 35 SR 1967]

Subp. 9. [Repealed, 35 SR 1967]

Subp. 10. [Repealed, 35 SR 1967]

Subp. 11. [Repealed, 35 SR 1967]

Subp. 12. [Repealed, 35 SR 1967]

Subp. 13. [Repealed, 35 SR 1967]

Subp. 14. [Repealed, 27 SR 1714; 35 SR 1967]

Subp. 15. [Repealed, 35 SR 1967]

Subp. 16. [Repealed, 35 SR 1967]

Subp. 17. [Repealed, 35 SR 1967]

Subp. 18. [Repealed, 35 SR 1967]

Subp. 19. [Repealed, 35 SR 1967]

Subp. 20. [Repealed, 35 SR 1967]

Subp. 21. [Repealed, 35 SR 1967]

Subp. 22. [Repealed, 17 SR 1454; 35 SR 1967]

Subp. 23. [Repealed, 35 SR 1967]

Subp. 24. [Repealed, 35 SR 1967]

Subp. 25. [Repealed, 35 SR 1967]

Subp. 26. [Repealed, 35 SR 1967]

Subp. 27. [Repealed, 35 SR 1967]

Subp. 28. [Repealed, 35 SR 1967]

Subp. 29. [Repealed, 35 SR 1967]

Subp. 30. [Repealed, 35 SR 1967]

Subp. 31. [Repealed, 35 SR 1967]

Subp. 32. [Repealed, 35 SR 1967]

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9505.0324 [Repealed, L 2003 1Sp14 art 4 s 24]

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9505.0325 NUTRITIONAL PRODUCTS.

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

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

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

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

A. phenylketonuria;

B. hyperlysinemia;

C. maple syrup urine disease; or

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

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

Subp. 6. **Payment limitations; long-term care facilities and hospitals.** An enteral nutritional product for a recipient in a long-term care facility or hospital is not eligible for payment on a separate claim for payment. Payment must be made according to parts 9500.1090 to 9500.1140, 9549.0010 to 9549.0080, and 9553.0010 to 9553.0080.

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *December 2, 2013*

9505.0326 [Repealed, L 2003 1Sp14 art 4 s 24]

Published Electronically: *August 12, 2008*

9505.0327 [Repealed, L 2003 1Sp14 art 4 s 24]

Published Electronically: *August 12, 2008*

9505.0330 OUTPATIENT HOSPITAL SERVICES.

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

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

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

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

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

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

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

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

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

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

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

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

A. diapers;

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 12, 2008*

9505.0335 PERSONAL CARE SERVICES.

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

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

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

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

(3) needs; and

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

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

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

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

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

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

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

H. "Qualified recipient" means a recipient who needs personal care services to live independently in the community, is in a stable medical condition, and does not have acute care needs that require inpatient hospitalization or cannot be met in the recipient's residence by a nursing service as defined by Minnesota Statutes, section 148.171, subdivision 15.

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

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

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

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

B. The recipient is a qualified recipient.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. comply with part 9505.0210;

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

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

G. provide a quality assurance mechanism;

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

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

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

K. demonstrate a system of personnel management; and

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

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

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

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

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

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

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

F. keep records as required in parts 9505.2160 to 9505.2195;

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

H. comply with applicable rules and statutes; and

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

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

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

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

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

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

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

A. bowel and bladder care;

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

C. range of motion exercises;

D. respiratory assistance;

E. transfers;

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

G. turning and positioning;

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

I. application and maintenance of prosthetics and orthotics;

J. cleaning equipment;

K. dressing or undressing;

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

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

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

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

A. personal care services in subpart 8;

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

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

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

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

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

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

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

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

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

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

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

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

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

Subp. 13. **Overutilization of personal care services.** A personal care provider who is found to be providing personal care services that are not medically necessary shall be prohibited from participating in the medical assistance program. The determination of whether excess services are provided shall be made by a screening team or according to parts 9505.2160 to 9505.2245. The termination of the personal care provider shall be consistent with the contract between the provider and the department.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; L 1990 c 375 s 3; L 1999 c 172 s 18*

Published Electronically: *October 16, 2013*

9505.0340 PHARMACY SERVICES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. The pharmacy's usual and customary charge.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; L 1988 c 689 art 2 s 268; L 2002 c 277 s 32*

Published Electronically: *October 16, 2013*

9505.0345 PHYSICIAN SERVICES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. artificial insemination;

B. procedure to reverse voluntary sterilization;

C. surgery primarily for cosmetic purposes;

D. services of a surgical assistant; and

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

Statutory Authority: *MS s 14.3895; 256B.04*

History: *12 SR 624; 34 SR 1135*

Published Electronically: *February 24, 2010*

9505.0350 PODIATRY SERVICES.

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

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

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

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

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

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

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

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

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

Subp. 5. **Payment limitation; more than one recipient on same day in same long-term care facility.** When a podiatry service is provided to more than one recipient who resides in the same long-term care facility by the same provider on the same day, payment for the provider's visit to the first recipient shall be according to part 9505.0445, item E, for the procedure code for the visit. The provider's visit on the same day to other recipients within the same long-term care facility must be billed with the multiple visit code established by the department. This subpart shall not apply to a provider's visit to provide an emergency service on the same day within the same long-term care facility if the emergency service could not have been scheduled consecutively with another recipient visit. If the provider visits other recipients in the same facility on the same day after providing an emergency service, the provider's visits must be billed with the multiple visit code.

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

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

B. surgical assistants;

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

D. operating room facility charges;

E. foot hygiene;

F. use of skin creams to maintain skin tone;

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 12, 2008*

9505.0353 PRENATAL CARE SERVICES.

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

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

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

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

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

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

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

Subp. 2. **Risk assessment.** To be eligible for medical assistance payment, a provider of prenatal care services shall complete a risk assessment for a recipient for whom the services are provided. The risk assessment must be completed at the recipient's first prenatal visit.

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

A. Prenatal care management must include:

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

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

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

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

B. Nutrition counseling includes:

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

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

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

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

C. Prenatal education includes:

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 30 SR 1318*

Published Electronically: *August 12, 2013*

9505.0355 PREVENTIVE HEALTH SERVICES.

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

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

A. be provided to the recipient in person;

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

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

D. not be part of another covered service;

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

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

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

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 12, 2008*

9505.0360 HOME CARE NURSING SERVICES.

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

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

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

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

B. service given during medically necessary ambulance services; and

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

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

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

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

C. The service may be provided only if:

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; L 1987 c 209 s 39; L 2014 c 291 art 9 s 5*

Published Electronically: *August 12, 2014*

9505.0365 PROSTHETIC AND ORTHOTIC DEVICES.

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

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

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

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

Subp. 2. [Repealed, L 2015 c 78 art 5 s 5]

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

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

Subp. 4. [Repealed, 17 SR 2042]

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

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

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

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

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

D. repair of a rented device;

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

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

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

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 17 SR 2042; L 2015 c 78 art 5 s 5*

Published Electronically: *August 31, 2015*

9505.0370 DEFINITIONS.

Subpart 1. **Scope.** For parts 9505.0370 to 9505.0372, the following terms have the meanings given them.

Subp. 2. **Adult day treatment.** "Adult day treatment" or "adult day treatment program" means a structured program of treatment and care.

Subp. 3. **Child.** "Child" means a person under 18 years of age.

Subp. 4. **Client.** "Client" means an eligible recipient who is determined to have or who is being assessed for a mental illness as specified in part 9505.0371.

Subp. 5. **Clinical summary.** "Clinical summary" means a written description of a clinician's formulation of the cause of the client's mental health symptoms, the client's prognosis, and the likely consequences of the symptoms; how the client meets the criteria for the diagnosis by describing the client's symptoms, the duration of symptoms, and functional impairment; an analysis of the client's other symptoms, strengths, relationships, life situations, cultural influences, and health concerns and their potential interaction with the diagnosis and formulation of the client's mental health condition; and alternative diagnoses that were considered and ruled out.

Subp. 6. **Clinical supervision.** "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.

Subp. 7. **Clinical supervisor.** "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.

Subp. 8. **Cultural competence or culturally competent.** "Cultural competence" or "culturally competent" means the mental health provider's:

A. awareness of the provider's own cultural background, and the related assumptions, values, biases, and preferences that influence assessment and intervention processes;

B. ability and will to respond to the unique needs of an individual client that arise from the client's culture;

C. ability to utilize the client's culture as a resource and as a means to optimize mental health care; and

D. willingness to seek educational, consultative, and learning experiences to expand knowledge of and increase effectiveness with culturally diverse populations.

Subp. 9. **Cultural influences.** "Cultural influences" means historical, geographical, and familial factors that affect assessment and intervention processes. Cultural influences that are relevant to the client may include the client's:

A. racial or ethnic self-identification;

B. experience of cultural bias as a stressor;

C. immigration history and status;

D. level of acculturation;

E. time orientation;

F. social orientation;

G. verbal communication style;

H. locus of control;

I. spiritual beliefs; and

J. health beliefs and the endorsement of or engagement in culturally specific healing practices.

Subp. 10. **Culture.** "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

Subp. 11. **Diagnostic assessment.** "Diagnostic assessment" means a written assessment that documents a clinical and functional face-to-face evaluation of the client's mental health, including the nature, severity and impact of behavioral difficulties, functional impairment, and subjective distress of the client, and identifies the client's strengths and resources.

Subp. 12. **Dialectical behavior therapy.** "Dialectical behavior therapy" means an evidence-based treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program is certified by the commissioner and involves the following service components: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

Subp. 13. **Explanation of findings.** "Explanation of findings" means the explanation of a client's diagnostic assessment, psychological testing, treatment program, and consultation with culturally informed mental health consultants as required under parts 9520.0900 to 9520.0926, or other accumulated data and recommendations to the client, client's family, primary caregiver, or other responsible persons.

Subp. 14. **Family.** "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited

to, parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, or persons who are presently residing together as a family unit.

Subp. 15. **Individual treatment plan.** "Individual treatment plan" means a written plan that outlines and defines the course of treatment. It delineates the goals, measurable objectives, target dates for achieving specific goals, main participants in treatment process, and recommended services that are based on the client's diagnostic assessment and other meaningful data that are needed to aid the client's recovery and enhance resiliency.

Subp. 16. **Medication management.** "Medication management" means a service that determines the need for or effectiveness of the medication prescribed for the treatment of a client's symptoms of a mental illness.

Subp. 17. **Mental health practitioner.** "Mental health practitioner" means a person who is qualified according to part 9505.0371, subpart 5, items B and C, and provides mental health services to a client with a mental illness under the clinical supervision of a mental health professional.

Subp. 18. **Mental health professional.** "Mental health professional" means a person who is enrolled to provide medical assistance services and is qualified according to part 9505.0371, subpart 5, item A.

Subp. 19. **Mental health telemedicine.** "Mental health telemedicine" has the meaning given in Minnesota Statutes, section 256B.0625, subdivision 46.

Subp. 20. **Mental illness.** "Mental illness" has the meaning given in Minnesota Statutes, section 245.462, subdivision 20. "Mental illness" includes "emotional disturbance" as defined in Minnesota Statutes, section 245.4871, subdivision 15.

Subp. 21. **Multidisciplinary staff.** "Multidisciplinary staff" means a group of individuals from diverse disciplines who come together to provide services to clients under part 9505.0372, subparts 8, 9, and 10.

Subp. 22. **Neuropsychological assessment.** "Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist.

Subp. 23. **Neuropsychological testing.** "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn and recall information; and use problem-solving and judgment.

Subp. 24. **Partial hospitalization program.** "Partial hospitalization program" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x, (ff), that is provided in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services.

Subp. 25. **Primary caregiver.** "Primary caregiver" means a person, other than the facility staff, who has primary legal responsibility for providing the client with food, clothing, shelter, direction, guidance, and nurturance.

Subp. 26. **Psychological testing.** "Psychological testing" means the use of tests or other psychometric instruments to determine the status of the recipient's mental, intellectual, and emotional functioning.

Subp. 27. **Psychotherapy.** "Psychotherapy" means treatment of a client with mental illness that applies the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client.

Subp. 28. **Supervisee.** "Supervisee" means an individual who requires clinical supervision because the individual does not meet mental health professional standards in part 9505.0371, subpart 5, item A.

Statutory Authority: *MS s 245.484; 256B.04*

History: *35 SR 1967*

Published Electronically: *July 5, 2011*

9505.0371 MEDICAL ASSISTANCE COVERAGE REQUIREMENTS FOR OUTPATIENT MENTAL HEALTH SERVICES.

Subpart 1. **Purpose.** This part describes the requirements that outpatient mental health services must meet to receive medical assistance reimbursement.

Subp. 2. **Client eligibility for mental health services.** The following requirements apply to mental health services:

A. The provider must use a diagnostic assessment as specified in part 9505.0372 to determine a client's eligibility for mental health services under this part, except:

(1) prior to completion of a client's initial diagnostic assessment, a client is eligible for:

(a) one explanation of findings;

(b) one psychological testing; and

(c) either one individual psychotherapy session, one family psychotherapy session, or one group psychotherapy session; and

(2) for a client who is not currently receiving mental health services covered by medical assistance, a crisis assessment as specified in Minnesota Statutes, section 256B.0624 or 256B.0944, conducted in the past 60 days may be used to allow up to ten sessions of mental health services within a 12-month period.

B. A brief diagnostic assessment must meet the requirements of part 9505.0372, subpart 1, item D, and:

(1) may be used to allow up to ten sessions of mental health services as specified in part 9505.0372 within a 12-month period before a standard or extended diagnostic assessment is required when the client is:

(a) a new client; or

(b) an existing client who has had fewer than ten sessions of psychotherapy in the previous 12 months and is projected to need fewer than ten sessions of psychotherapy in the next 12 months, or who only needs medication management; and

(2) may be used for a subsequent annual assessment, if based upon the client's treatment history and the provider's clinical judgment, the client will need ten or fewer sessions of mental health services in the upcoming 12-month period; and

(3) must not be used for:

(a) a client or client's family who requires a language interpreter to participate in the assessment unless the client meets the requirements of subitem (1), unit (b), or (2); or

(b) more than ten sessions of mental health services in a 12-month period. If, after completion of ten sessions of mental health services, the mental health professional determines the need for additional sessions, a standard assessment or extended assessment must be completed.

C. For a child, a new standard or extended diagnostic assessment must be completed:

(1) when the child does not meet the criteria for a brief diagnostic assessment;

(2) at least annually following the initial diagnostic assessment, if:

(a) additional services are needed; and

(b) the child does not meet criteria for brief assessment;

(3) when the child's mental health condition has changed markedly since the child's most recent diagnostic assessment; or

(4) when the child's current mental health condition does not meet criteria of the child's current diagnosis.

D. For an adult, a new standard diagnostic assessment or extended diagnostic assessment must be completed:

(1) when the adult does not meet the criteria for a brief diagnostic assessment or an adult diagnostic assessment update;

(2) at least every three years following the initial diagnostic assessment for an adult who receives mental health services;

(3) when the adult's mental health condition has changed markedly since the adult's most recent diagnostic assessment; or

(4) when the adult's current mental health condition does not meet criteria of the current diagnosis.

E. An adult diagnostic assessment update must be completed at least annually unless a new standard or extended diagnostic assessment is performed. An adult diagnostic assessment update must include an update of the most recent standard or extended diagnostic assessment and any recent adult diagnostic assessment updates that have occurred since the last standard or extended diagnostic assessment.

Subp. 3. **Authorization for mental health services.** Mental health services under this part are subject to authorization criteria and standards published by the commissioner according to Minnesota Statutes, section 256B.0625, subdivision 25.

Subp. 4. **Clinical supervision.**

A. Clinical supervision must be based on each supervisee's written supervision plan and must:

(1) promote professional knowledge, skills, and values development;

(2) model ethical standards of practice;

(3) promote cultural competency by:

(a) developing the supervisee's knowledge of cultural norms of behavior for individual clients and generally for the clients served by the supervisee regarding the client's cultural influences, age, class, gender, sexual orientation, literacy, and mental or physical disability;

(b) addressing how the supervisor's and supervisee's own cultures and privileges affect service delivery;

(c) developing the supervisee's ability to assess their own cultural competence and to identify when consultation or referral of the client to another provider is needed; and

(d) emphasizing the supervisee's commitment to maintaining cultural competence as an ongoing process;

(4) recognize that the client's family has knowledge about the client and will continue to play a role in the client's life and encourage participation among the client, client's family, and providers as treatment is planned and implemented; and

(5) monitor, evaluate, and document the supervisee's performance of assessment, treatment planning, and service delivery.

B. Clinical supervision must be conducted by a qualified supervisor using individual or group supervision. Individual or group face-to-face supervision may be conducted via electronic communications that utilize interactive telecommunications equipment that includes at a minimum audio and video equipment for two-way, real-time, interactive communication between the supervisor and supervisee, and meet the equipment and connection standards of part 9505.0370, subpart 19.

(1) Individual supervision means one or more designated clinical supervisors and one supervisee.

(2) Group supervision means one clinical supervisor and two to six supervisees in face-to-face supervision.

C. The supervision plan must be developed by the supervisor and the supervisee. The plan must be reviewed and updated at least annually. For new staff the plan must be completed and implemented within 30 days of the new staff person's employment. The supervision plan must include:

(1) the name and qualifications of the supervisee and the name of the agency in which the supervisee is being supervised;

(2) the name, licensure, and qualifications of the supervisor;

(3) the number of hours of individual and group supervision to be completed by the supervisee including whether supervision will be in person or by some other method approved by the commissioner;

(4) the policy and method that the supervisee must use to contact the clinical supervisor during service provision to a supervisee;

(5) procedures that the supervisee must use to respond to client emergencies; and

(6) authorized scope of practices, including:

(a) description of the supervisee's service responsibilities;

(b) description of client population; and

(c) treatment methods and modalities.

D. Clinical supervision must be recorded in the supervisee's supervision record. The documentation must include:

(1) date and duration of supervision;

(2) identification of supervision type as individual or group supervision;

(3) name of the clinical supervisor;

(4) subsequent actions that the supervisee must take; and

(5) date and signature of the clinical supervisor.

E. Clinical supervision pertinent to client treatment changes must be recorded by a case notation in the client record after supervision occurs.

Subp. 5. **Qualified providers.** Medical assistance covers mental health services according to part 9505.0372 when the services are provided by mental health professionals or mental health practitioners qualified under this subpart.

A. A mental health professional must be qualified in one of the following ways:

(1) in clinical social work, a person must be licensed as an independent clinical social worker by the Minnesota Board of Social Work under Minnesota Statutes, chapter 148D until August 1, 2011, and thereafter under Minnesota Statutes, chapter 148E;

(2) in psychology, a person licensed by the Minnesota Board of Psychology under Minnesota Statutes, sections 148.88 to 148.98, who has stated to the board competencies in the diagnosis and treatment of mental illness;

(3) in psychiatry, a physician licensed under Minnesota Statutes, chapter 147, who is certified by the American Board of Psychiatry and Neurology or is eligible for board certification;

(4) in marriage and family therapy, a person licensed as a marriage and family therapist by the Minnesota Board of Marriage and Family Therapy under Minnesota Statutes, sections 148B.29 to 148B.39, and defined in parts 5300.0100 to 5300.0350;

(5) in professional counseling, a person licensed as a professional clinical counselor by the Minnesota Board of Behavioral Health and Therapy under Minnesota Statutes, section 148B.5301;

(6) a tribally approved mental health care professional, who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), and who is serving a federally recognized Indian tribe; or

(7) in psychiatric nursing, a registered nurse who is licensed under Minnesota Statutes, sections 148.171 to 148.285, and meets one of the following criteria:

(a) is certified as a clinical nurse specialist;

(b) for children, is certified as a nurse practitioner in child or adolescent or family psychiatric and mental health nursing by a national nurse certification organization; or

(c) for adults, is certified as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization.

B. A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults. A mental health practitioner must be qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university; and

(a) has at least 2,000 hours of supervised experience in the delivery of mental health services to clients with mental illness; or

(b) is fluent in the non-English language of the cultural group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once a week until the requirements of 2,000 hours of supervised experience are met;

(2) has at least 6,000 hours of supervised experience in the delivery of mental health services to clients with mental illness. Hours worked as a mental health behavioral aide I or II under Minnesota Statutes, section 256B.0943, subdivision 7, may be included in the 6,000 hours of experience for child clients;

(3) is a graduate student in one of the mental health professional disciplines defined in item A and is formally assigned by an accredited college or university to an agency or facility for clinical training;

(4) holds a master's or other graduate degree in one of the mental health professional disciplines defined in item A from an accredited college or university; or

(5) is an individual who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), who is serving a federally recognized Indian tribe.

C. Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy performed by a mental health practitioner working as a clinical trainee when:

(1) the mental health practitioner is:

(a) complying with requirements for licensure or board certification as a mental health professional, as defined in item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or

(b) a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional defined in item A; and

(2) the mental health practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of:

(a) direct practice;

(b) treatment team collaboration;

(c) continued professional learning; and

(d) job management.

D. A clinical supervisor must:

(1) be a mental health professional licensed as specified in item A;

(2) hold a license without restrictions that has been in good standing for at least one year while having performed at least 1,000 hours of clinical practice;

(3) be approved, certified, or in some other manner recognized as a qualified clinical supervisor by the person's professional licensing board, when this is a board requirement;

(4) be competent as demonstrated by experience and graduate-level training in the area of practice and the activities being supervised;

(5) not be the supervisee's blood or legal relative or cohabitant, or someone who has acted as the supervisee's therapist within the past two years;

(6) have experience and skills that are informed by advanced training, years of experience, and mastery of a range of competencies that demonstrate the following:

(a) capacity to provide services that incorporate best practice;

(b) ability to recognize and evaluate competencies in supervisees;

(c) ability to review assessments and treatment plans for accuracy and appropriateness;

(d) ability to give clear direction to mental health staff related to alternative strategies when a client is struggling with moving towards recovery; and

(e) ability to coach, teach, and practice skills with supervisees;

(7) accept full professional liability for a supervisee's direction of a client's mental health services;

(8) instruct a supervisee in the supervisee's work, and oversee the quality and outcome of the supervisee's work with clients;

(9) review, approve, and sign the diagnostic assessment, individual treatment plans, and treatment plan reviews of clients treated by a supervisee;

(10) review and approve the progress notes of clients treated by the supervisee according to the supervisee's supervision plan;

(11) apply evidence-based practices and research-informed models to treat clients;

(12) be employed by or under contract with the same agency as the supervisee;

(13) develop a clinical supervision plan for each supervisee;

(14) ensure that each supervisee receives the guidance and support needed to provide treatment services in areas where the supervisee practices;

(15) establish an evaluation process that identifies the performance and competence of each supervisee; and

(16) document clinical supervision of each supervisee and securely maintain the documentation record.

Subp. 6. **Release of information.** Providers who receive a request for client information and providers who request client information must:

A. comply with data practices and medical records standards in Minnesota Statutes, chapter 13, and Code of Federal Regulations, title 45, part 164; and

B. subject to the limitations in item A, promptly provide client information, including a written diagnostic assessment, to other providers who are treating the client to ensure that the client will get services without undue delay.

Subp. 7. **Individual treatment plan.** Except as provided in subpart 2, item A, subitem (1), a medical assistance payment is available only for services provided in accordance with the client's written individual treatment plan (ITP). The client must be involved in the development, review, and revision of the client's ITP. For all mental health services, except as provided in subpart 2, item A, subitem (1), and medication management, the ITP and subsequent revisions of the ITP must be signed by the client before treatment begins. The mental health professional or practitioner shall request the client, or other person authorized by statute to consent to mental health services for the client, to sign the client's ITP or revision of the ITP. In the case of a child, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child shall be asked to sign the child's ITP and revisions of the ITP. If the client or authorized person refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner shall note on the plan the refusal to sign the plan and the reason or reasons for the refusal. A client's individual treatment plan must be:

A. based on the client's current diagnostic assessment;

B. developed by identifying the client's service needs and considering relevant cultural influences to identify planned interventions that contain specific treatment goals and measurable objectives for the client; and

C. reviewed at least once every 90 days, and revised as necessary. Revisions to the initial individual treatment plan do not require a new diagnostic assessment unless the client's mental health status has changed markedly as provided in subpart 2.

Subp. 8. **Documentation.** To obtain medical assistance payment for an outpatient mental health service, a mental health professional or a mental health practitioner must promptly document:

A. in the client's mental health record:

(1) each occurrence of service to the client including the date, type of service, start and stop time, scope of the mental health service, name and title of the person who gave the service, and date of documentation; and

(2) all diagnostic assessments and other assessments, psychological test results, treatment plans, and treatment plan reviews;

B. the provider's contact with persons interested in the client such as representatives of the courts, corrections systems, or schools, or the client's other mental health providers, case manager, family, primary caregiver, legal representative, including the name and date of the contact or, if applicable, the reason the client's family, primary caregiver, or legal representative was not contacted; and

C. dates that treatment begins and ends and reason for the discontinuation of the mental health service.

Subp. 9. **Service coordination.** The provider must coordinate client services as authorized by the client as follows:

A. When a recipient receives mental health services from more than one mental health provider, each provider must coordinate mental health services they provide to the client with other mental health

service providers to ensure services are provided in the most efficient manner to achieve maximum benefit for the client.

B. The mental health provider must coordinate mental health care with the client's physical health provider.

Subp. 10. **Telemedicine services.** Mental health services in part 9505.0372 covered as direct face-to-face services may be provided via two-way interactive video if it is medically appropriate to the client's condition and needs. The interactive video equipment and connection must comply with Medicare standards that are in effect at the time of service. The commissioner may specify parameters within which mental health services can be provided via telemedicine.

Statutory Authority: *MS s 245.484; 256B.04*

History: *35 SR 1967*

Published Electronically: *July 5, 2011*

9505.0372 COVERED SERVICES.

Subpart 1. **Diagnostic assessment.** Medical assistance covers four types of diagnostic assessments when they are provided in accordance with the requirements in this subpart.

A. To be eligible for medical assistance payment, a diagnostic assessment must:

(1) identify a mental health diagnosis and recommended mental health services, which are the factual basis to develop the recipient's mental health services and treatment plan; or

(2) include a finding that the client does not meet the criteria for a mental health disorder.

B. A standard diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The standard diagnostic assessment must be done within the cultural context of the client and must include relevant information about:

(1) the client's current life situation, including the client's:

(a) age;

(b) current living situation, including household membership and housing status;

(c) basic needs status including economic status;

(d) education level and employment status;

(e) significant personal relationships, including the client's evaluation of relationship quality;

(f) strengths and resources, including the extent and quality of social networks;

(g) belief systems;

(h) contextual nonpersonal factors contributing to the client's presenting concerns;

(i) general physical health and relationship to client's culture; and

(j) current medications;

(2) the reason for the assessment, including the client's:

(a) perceptions of the client's condition;

(b) description of symptoms, including reason for referral;

(c) history of mental health treatment, including review of the client's records;

(d) important developmental incidents;

(e) maltreatment, trauma, or abuse issues;

(f) history of alcohol and drug usage and treatment;

(g) health history and family health history, including physical, chemical, and mental health history; and

(h) cultural influences and their impact on the client;

(3) the client's mental status examination;

(4) the assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(5) the screenings used to determine the client's substance use, abuse, or dependency and other standardized screening instruments determined by the commissioner;

(6) assessment methods and use of standardized assessment tools by the provider as determined and periodically updated by the commissioner;

(7) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(8) the client data that is adequate to support the findings on all axes of the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association; and any differential diagnosis.

C. An extended diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The face-to-face interview is conducted over three or more assessment appointments because the client's complex needs necessitate significant additional assessment time. Complex needs are those caused by acuity of psychotic disorder; cognitive or neurocognitive impairment; need to consider past diagnoses and determine their current applicability; co-occurring substance abuse use disorder; or disruptive or changing environments, communication barriers, or cultural considerations as documented in the assessment. For child clients, the appointments may be conducted outside the diagnostician's office for face-to-face consultation and information gathering with family members, doctors, caregivers, teachers, and other providers, with or without the child present, and may involve directly observing the child in various settings that the child frequents such as home, school, or care settings. To complete the diagnostic assessment with adult clients, the appointments may be conducted outside of the diagnostician's office for face-to-face assessment with the adult client. The appointment may involve directly observing the adult client in various settings that the adult frequents, such as home, school, job, service settings, or community settings. The appointments may include face-to-face meetings with the adult client and the client's family members, doctors, caregivers, teachers, social support network members, recovery support resource representatives, and other providers

for consultation and information gathering for the diagnostic assessment. The components of an extended diagnostic assessment include the following relevant information:

(1) for children under age 5:

(a) utilization of the DC:0-3R diagnostic system for young children;

(b) an early childhood mental status exam that assesses the client's developmental, social, and emotional functioning and style both within the family and with the examiner and includes:

i. physical appearance including dysmorphic features;

ii. reaction to new setting and people and adaptation during evaluation;

iii. self-regulation, including sensory regulation, unusual behaviors, activity level, attention span, and frustration tolerance;

iv. physical aspects, including motor function, muscle tone, coordination, tics, abnormal movements, and seizure activity;

v. vocalization and speech production, including expressive and receptive language;

vi. thought, including fears, nightmares, dissociative states, and hallucinations;

vii. affect and mood, including modes of expression, range, responsiveness, duration, and intensity;

viii. play, including structure, content, symbolic functioning, and modulation of aggression;

ix. cognitive functioning; and

x. relatedness to parents, other caregivers, and examiner; and

(c) other assessment tools as determined and periodically revised by the commissioner;

(2) for children ages 5 to 18, completion of other assessment standards for children as determined and periodically revised by the commissioner; and

(3) for adults, completion of other assessment standards for adults as determined and periodically revised by the commissioner.

D. A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The professional or practitioner must gather initial background information using the components of a standard diagnostic assessment in item B, subitems (1), (2), unit (b), (3), and (5), and draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem. Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.

E. Adult diagnostic assessment update includes a face-to-face interview with the client, and contains a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C, who reviews a

standard or extended diagnostic assessment. The adult diagnostic assessment update must update the most recent assessment document in writing in the following areas:

(1) review of the client's life situation, including an interview with the client about the client's current life situation, and a written update of those parts where significant new or changed information exists, and documentation where there has not been significant change;

(2) review of the client's presenting problems, including an interview with the client about current presenting problems and a written update of those parts where there is significant new or changed information, and note parts where there has not been significant change;

(3) screenings for substance use, abuse, or dependency and other screenings as determined by the commissioner;

(4) the client's mental health status examination;

(5) assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(6) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary, or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(7) the client's diagnosis on all axes of the current edition of the Diagnostic and Statistical Manual and any differential diagnosis.

Subp. 2. **Neuropsychological assessment.** A neuropsychological assessment must include a face-to-face interview with the client, the interpretation of the test results, and preparation and completion of a report. A client is eligible for a neuropsychological assessment if at least one of the following criteria is met:

A. There is a known or strongly suspected brain disorder based on medical history or neurological evaluation such as a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorders, significant exposure to neurotoxins, central nervous system infections, metabolic or toxic encephalopathy, fetal alcohol syndrome, or congenital malformations of the brain; or

B. In the absence of a medically verified brain disorder based on medical history or neurological evaluation, there are cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology, or suspected neuropsychological impairment in addition to functional psychopathology. Examples include:

(1) poor memory or impaired problem solving;

(2) change in mental status evidenced by lethargy, confusion, or disorientation;

(3) deterioration in level of functioning;

(4) marked behavioral or personality change;

(5) in children or adolescents, significant delays in academic skill acquisition or poor attention relative to peers;

(6) in children or adolescents, significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers; and

(7) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

C. If neither criterion in item A nor B is fulfilled, neuropsychological evaluation is not indicated.

D. The neuropsychological assessment must be conducted by a neuropsychologist with competence in the area of neuropsychological assessment as stated to the Minnesota Board of Psychology who:

(1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;

(2) earned a doctoral degree in psychology from an accredited university training program:

(a) completed an internship, or its equivalent, in a clinically relevant area of professional psychology;

(b) completed the equivalent of two full-time years of experience and specialized training, at least one which is at the postdoctoral level, in the study and practices of clinical neuropsychology and related neurosciences supervised by a clinical neuropsychologist; and

(c) holds a current license to practice psychology independently in accordance with Minnesota Statutes, sections 148.88 to 148.98;

(3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in subitem (1); or

(4) was approved by the commissioner as an eligible provider of neuropsychological assessment prior to December 31, 2010.

Subp. 3. **Neuropsychological testing.**

A. Medical assistance covers neuropsychological testing when the client has either:

(1) a significant mental status change that is not a result of a metabolic disorder that has failed to respond to treatment;

(2) in children or adolescents, a significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers;

(3) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities, as required to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(a) traumatic brain injury;

(b) stroke;

(c) brain tumor;

(d) substance abuse or dependence;

(e) cerebral anoxic or hypoxic episode;

(f) central nervous system infection or other infectious disease;

(g) neoplasms or vascular injury of the central nervous system;

(h) neurodegenerative disorders;

(i) demyelinating disease;

(j) extrapyramidal disease;

(k) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(l) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders such as lupus, erythematosis, or celiac disease;

(m) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, such as phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(n) severe or prolonged nutrition or malabsorption syndromes; or

(o) a condition presenting in a manner making it difficult for a clinician to distinguish between:

i. the neurocognitive effects of a neurogenic syndrome such as dementia or encephalopathy; and

ii. a major depressive disorder when adequate treatment for major depressive disorder has not resulted in improvement in neurocognitive function, or another disorder such as autism, selective mutism, anxiety disorder, or reactive attachment disorder.

B. Neuropsychological testing must be administered or clinically supervised by a neuropsychologist qualified as defined in subpart 2, item D.

C. Neuropsychological testing is not covered when performed:

(1) primarily for educational purposes;

(2) primarily for vocational counseling or training;

(3) for personnel or employment testing;

(4) as a routine battery of psychological tests given at inpatient admission or continued stay; or

(5) for legal or forensic purposes.

Subp. 4. **Psychological testing.** Psychological testing must meet the following requirements:

A. The psychological testing must:

(1) be administered or clinically supervised by a licensed psychologist with competence in the area of psychological testing as stated to the Minnesota Board of Psychology; and

(2) be validated in a face-to-face interview between the client and a licensed psychologist or a mental health practitioner working as a clinical psychology trainee as required by part 9505.0371, subpart 5, item C, under the clinical supervision of a licensed psychologist according to part 9505.0371, subpart 5, item A, subitem (2).

B. The administration, scoring, and interpretation of the psychological tests must be done under the clinical supervision of a licensed psychologist when performed by a technician, psychometrist, or psychological assistant or as part of a computer-assisted psychological testing program.

C. The report resulting from the psychological testing must be:

(1) signed by the psychologist conducting the face-to-face interview;

(2) placed in the client's record; and

(3) released to each person authorized by the client.

Subp. 5. **Explanations of findings.** To be eligible for medical assistance payment, the mental health professional providing the explanation of findings must obtain the authorization of the client or the client's representative to release the information as required in part 9505.0371, subpart 6. Explanation of findings is provided to the client, client's family, and caregivers, or to other providers to help them understand the results of the testing or diagnostic assessment, better understand the client's illness, and provide professional insight needed to carry out a plan of treatment. An explanation of findings is not paid separately when the results of psychological testing or a diagnostic assessment are explained to the client or the client's representative as part of the psychological testing or a diagnostic assessment.

Subp. 6. **Psychotherapy.** Medical assistance covers psychotherapy as conducted by a mental health professional or a mental health practitioner as defined in part 9505.0371, subpart 5, item C, as provided in this subpart.

A. Individual psychotherapy is psychotherapy designed for one client.

B. Family psychotherapy is designed for the client and one or more family members or the client's primary caregiver whose participation is necessary to accomplish the client's treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance. For purposes of this subpart, the phrase "whose participation is necessary to accomplish the client's treatment goals" does not include shift or facility staff members at the client's residence. Medical assistance payment for family psychotherapy is limited to face-to-face sessions at which the client is present throughout the family psychotherapy session unless the mental health professional believes the client's absence from the family psychotherapy session is necessary to carry out the client's individual treatment plan. If the client is excluded, the mental health professional must document the reason for and the length of time of the exclusion. The mental health professional must also document the reason or reasons why a member of the client's family is excluded.

C. Group psychotherapy is appropriate for individuals who because of the nature of their emotional, behavioral, or social dysfunctions can derive mutual benefit from treatment in a group setting. For a group of three to eight persons, one mental health professional or practitioner is required to conduct the group. For a group of nine to 12 persons, a team of at least two mental health professionals or two mental health practitioners or one mental health professional and one mental health practitioner is required to co-conduct the group. Medical assistance payment is limited to a group of no more than 12 persons.

D. A multiple-family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least two but not more than five families. Multiple-family group psychotherapy is clearly directed toward meeting the identified treatment needs of each client as indicated in client's treatment plan. If the client is excluded, the mental health professional or practitioner must document the reason for and the length of the time of the exclusion. The mental health professional or practitioner must document the reasons why a member of the client's family is excluded.

Subp. 7. **Medication management.** The determination or evaluation of the effectiveness of a client's prescribed drug must be carried out by a physician or by an advanced practice registered nurse, as defined in Minnesota Statutes, sections 148.71 to 148.285, who is qualified in psychiatric nursing.

Subp. 8. **Adult day treatment.** Adult day treatment payment limitations include the following conditions.

A. Adult day treatment must consist of at least one hour of group psychotherapy, and must include group time focused on rehabilitative interventions, or other therapeutic services that are provided by a multidisciplinary staff. Adult day treatment is an intensive psychotherapeutic treatment. The services must stabilize the client's mental health status, and develop and improve the client's independent living and socialization skills. The goal of adult day treatment is to reduce or relieve the effects of mental illness so that an individual is able to benefit from a lower level of care and to enable the client to live and function more independently in the community. Day treatment services are not a part of inpatient or residential treatment services.

B. To be eligible for medical assistance payment, a day treatment program must:

(1) be reviewed by and approved by the commissioner;

(2) be provided to a group of clients by a multidisciplinary staff under the clinical supervision of a mental health professional;

(3) be available to the client at least two days a week for at least three consecutive hours per day. The day treatment may be longer than three hours per day, but medical assistance must not reimburse a provider for more than 15 hours per week;

(4) include group psychotherapy done by a mental health professional, or mental health practitioner qualified according to part 9505.0371, subpart 5, item C, and rehabilitative interventions done by a mental health professional or mental health practitioner daily;

(5) be included in the client's individual treatment plan as necessary and appropriate. The individual treatment plan must include attainable, measurable goals as they relate to services and must be completed before the first day treatment session. The vendor must review the recipient's progress and update the treatment plan at least every 30 days until the client is discharged and include an available discharge plan for the client in the treatment plan; and

(6) document the interventions provided and the client's response daily.

C. To be eligible for adult day treatment, a recipient must:

(1) be 18 years of age or older;

(2) not be residing in a nursing facility, hospital, institute of mental disease, or regional treatment center, unless the recipient has an active discharge plan that indicates a move to an independent living arrangement within 180 days;

(3) have a diagnosis of mental illness as determined by a diagnostic assessment;

(4) have the capacity to engage in the rehabilitative nature, the structured setting, and the therapeutic parts of psychotherapy and skills activities of a day treatment program and demonstrate measurable improvements in the recipient's functioning related to the recipient's mental illness that would result from participating in the day treatment program;

(5) have at least three areas of functional impairment as determined by a functional assessment with the domains prescribed by Minnesota Statutes, section 245.462, subdivision 11a;

(6) have a level of care determination that supports the need for the level of intensity and duration of a day treatment program; and

(7) be determined to need day treatment by a mental health professional who must deem the day treatment services medically necessary.

D. The following services are not covered by medical assistance if they are provided by a day treatment program:

(1) a service that is primarily recreation-oriented or that is provided in a setting that is not medically supervised. This includes: sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(2) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(3) consultation with other providers or service agency staff about the care or progress of a client;

(4) prevention or education programs provided to the community;

(5) day treatment for recipients with primary diagnoses of alcohol or other drug abuse;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours daily; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

Subp. 9. **Partial hospitalization.** Partial hospitalization is a covered service when it is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission as specified in part 9505.0520, subpart 1, and who has the family and community resources necessary and appropriate to support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services provided by a multidisciplinary staff to treat the client's mental illness.

Subp. 10. **Dialectical behavior therapy (DBT).** Dialectical behavior therapy (DBT) treatment services must meet the following criteria:

A. DBT must be provided according to this subpart and Minnesota Statutes, section 256B.0625, subdivision 5l.

B. DBT is an outpatient service that is determined to be medically necessary by either: (1) a mental health professional qualified according to part 9505.0371, subpart 5, or (2) a mental health practitioner working as a clinical trainee according to part 9505.0371, subpart 5, item C, who is under the clinical supervision of a mental health professional according to part 9505.0371, subpart 5, item D, with specialized skill in dialectical behavior therapy. The treatment recommendation must be based upon a comprehensive evaluation that includes a diagnostic assessment and functional assessment of the client, and review of the client's prior treatment history. Treatment services must be provided pursuant to the client's individual treatment plan and provided to a client who satisfies the criteria in item C.

C. To be eligible for DBT, a client must:

(1) be 18 years of age or older;

(2) have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community-based services;

(3) meet one of the following criteria:

(a) have a diagnosis of borderline personality disorder; or

(b) have multiple mental health diagnoses and exhibit behaviors characterized by impulsivity, intentional self-harm behavior, and be at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas;

(4) understand and be cognitively capable of participating in DBT as an intensive therapy program and be able and willing to follow program policies and rules assuring safety of self and others; and

(5) be at significant risk of one or more of the following if DBT is not provided:

(a) mental health crisis;

(b) requiring a more restrictive setting such as hospitalization;

(c) decompensation; or

(d) engaging in intentional self-harm behavior.

D. The treatment components of DBT are individual therapy and group skills as follows:

(1) Individual DBT combines individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and reinforce the use of adaptive skillful behaviors. The therapist must:

(a) identify, prioritize, and sequence behavioral targets;

(b) treat behavioral targets;

(c) generalize DBT skills to the client's natural environment through telephone coaching outside of the treatment session;

(d) measure the client's progress toward DBT targets;

(e) help the client manage crisis and life-threatening behaviors; and

(f) help the client learn and apply effective behaviors when working with other treatment providers.

(2) Individual DBT therapy is provided by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

(3) Group DBT skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group format to reduce the client's suicidal and other dysfunctional coping behaviors and restore function by teaching the client adaptive skills in the following areas:

(a) mindfulness;

(b) interpersonal effectiveness;

(c) emotional regulation; and

(d) distress tolerance.

(4) Group DBT skills training is provided by two mental health professionals, or by a mental health professional cofacilitating with a mental health practitioner.

(5) The need for individual DBT skills training must be determined by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

E. A program must be certified by the commissioner as a DBT provider. To qualify for certification, a provider must:

(1) hold current accreditation as a DBT program from a nationally recognized certification body approved by the commissioner or submit to the commissioner's inspection and provide evidence that the DBT program's policies, procedures, and practices will continuously meet the requirements of this subpart;

(2) be enrolled as a MHCP provider;

(3) collect and report client outcomes as specified by the commissioner; and

(4) have a manual that outlines the DBT program's policies, procedures, and practices which meet the requirements of this subpart.

F. The DBT treatment team must consist of persons who are trained in DBT treatment. The DBT treatment team may include persons from more than one agency. Professional and clinical affiliations with the DBT team must be delineated:

(1) A DBT team leader must:

(a) be a mental health professional employed by, affiliated with, or contracted by a DBT program certified by the commissioner;

(b) have appropriate competencies and working knowledge of the DBT principles and practices; and

(c) have knowledge of and ability to apply the principles and DBT practices that are consistent with evidence-based practices.

(2) DBT team members who provide individual DBT or group skills training must:

(a) be a mental health professional or be a mental health practitioner, who is employed by, affiliated with, or contracted with a DBT program certified by the commissioner;

(b) have or obtain appropriate competencies and working knowledge of DBT principles and practices within the first six months of becoming a part of the DBT program;

(c) have or obtain knowledge of and ability to apply the principles and practices of DBT consistently with evidence-based practices within the first six months of working at the DBT program;

(d) participate in DBT consultation team meetings; and

(e) require mental health practitioners to have ongoing clinical supervision by a mental health professional who has appropriate competencies and working knowledge of DBT principles and practices.

Subp. 11. **Noncovered services.** The mental health services in items A to J are not eligible for medical assistance payment under this part:

A. a mental health service that is not medically necessary;

B. a neuropsychological assessment carried out by a person other than a neuropsychologist who is qualified according to part 9505.0372, subpart 2, item D;

C. a service ordered by a court that is solely for legal purposes and not related to the recipient's diagnosis or treatment for mental illness;

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

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

F. staff training that is not related to a client's individual treatment plan or plan of care;

G. child and adult protection services;

H. fund-raising activities;

I. community planning; and

J. client transportation.

Statutory Authority: *MS s 245.484; 256B.04*

History: *35 SR 1967*

Published Electronically: *October 16, 2013*

9505.0380 PUBLIC HEALTH CLINIC SERVICES.

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

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

A. physician services as in part 9505.0345;

B. preventive health services as in part 9505.0355;

C. family planning services as in part 9505.0280;

D. prenatal care services as in part 9505.0353;

E. dental services as in part 9505.0270; and

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 12, 2008*

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*

Published Electronically: *August 12, 2008*

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, part 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 parts 9505.0370 to 9505.0372 shall be eligible for medical assistance payment.

Statutory Authority: *MS s 245.484; 256B.04*

History: *15 SR 2404; 35 SR 1967*

Published Electronically: *July 5, 2011*

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 maintains state licensure and registration requirements and meets the requirements of Code of Federal Regulations, title 42, chapter IV, subchapter C, part 440, subpart A, section 440.110.

B. "Delegation of duties" means, notwithstanding any other definition of direction in parts 9505.0170 to 9505.0475, the actions of a physical or occupational therapist who delegates to the physical therapist assistant or the occupational therapy assistant specific duties to be performed, monitors the provision of services as the therapy assistants provide the service, and meets the supervisory requirements of Minnesota Statutes, sections 148.706 and 148.6432, respectively when treatment is provided by a physical therapist assistant or occupational therapy assistant.

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 meets the requirements of Code of Federal Regulations, title 42, chapter IV, subchapter C, part 440, subpart A, section 440.110, and maintains applicable state licensure or is in compliance with state regulatory requirements in states that do not license.

E. "Occupational therapy assistant" means a person who has been certified by the National Board for Certification in Occupational Therapy and maintains applicable state licensure or is in compliance with state regulatory requirements in states that do not license an occupational therapy assistant.

F. "Physical therapist" means a person who is a graduate of a program of physical therapy accredited by the Commission on Accreditation in Physical Therapy Education or its equivalent, meets the requirements of Code of Federal Regulations, title 42, chapter IV, subchapter C, part 440, subpart A, section 440.110, and maintains applicable state licensure or is in compliance with state regulatory requirements in states that do not license.

G. "Physical therapist assistant" means a person who has successfully completed all academic and field work requirements of a physical therapist assistant program accredited by the Commission on Accreditation in Physical Therapy Education, and maintains applicable state licensure or is in compliance with state regulatory requirements in states that do not license.

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 4658.0525.

J. "Restorative therapy" means a health service that is specified in the recipient's plan of care and certified by a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law that the service 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 and certified by a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law 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 completing the clinical fellowship year required for certification as a speech-language pathologist, or a person who has a certificate of clinical competence in speech-language pathology from the American Speech-Language-Hearing Association and, when it is applicable, maintains state licensure or is in compliance with state regulatory requirements in states that do not license and meets the requirements of Code of Federal Regulations, title 42, chapter IV, subchapter C, part 440, subpart A, section 440.110.

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 or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law;

B. provided by a physical or occupational therapist or by a physical therapist assistant or occupational therapy assistant who, as appropriate, is under the supervision of a physical or occupational therapist as defined in part 9505.0390, subpart 1, items D to G;

C. provided to a recipient whose functional status is expected by the physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law to progress toward or achieve the objectives in the recipient's plan of care within a 90-day period; and

D. specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's attending physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 90 days. If the service is provided to a recipient who is also eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed in compliance with Code of Federal Regulations, title 42, chapter IV, subchapter G, part 485, subpart H, section 485.711.

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 other licensed practitioner of the healing arts within the practitioner's scope of practice under state law 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 as defined in part 9505.0390, subpart 1, item L;

C. provided to a recipient whose functional status is expected by the physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law to progress toward or achieve the objectives in the recipient's plan of care within a 90-day period; and

D. specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's attending physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 90 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 in compliance with Code of Federal Regulations, title 42, chapter IV, subchapter G, part 485, subpart H, section 485.711.

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 or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law;

B. provided by an audiologist as defined in subpart 1, item A;

C. provided to a recipient whose functional status is expected by the physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law to progress toward or achieve the objectives in the recipient's plan of care within a 90-day period; and

D. specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's attending physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 90 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 in compliance with Code of Federal Regulations, title 42, chapter IV, subchapter G, part 485, subpart H, section 485.711.

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

A. be provided by a physical therapist, physical therapy assistant, occupational therapist, occupational therapy assistant, or speech-language pathologist;

B. be specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 90 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;

C. be provided to a recipient whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because the recipient's physical, cognitive, or psychological deficits result in:

(1) spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care, or decreased functional ability compared to the recipient's previous level of function;

(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, cardiovascular function, integumentary status, or positioning necessary for completion of the recipient's activities of daily living, or decreased abilities relevant to the recipient's current environmental demands; or

(3) health and safety risks for the recipient;

D. have expected outcomes that are functional, realistic, relevant, and transferable to the recipient's current or anticipated environment, such as home, school, community, and work, and be consistent with community standards; and

E. meet at least one of the criteria in subitems (1) to (3):

(1) prevent deterioration and sustain function;

(2) provide interventions, in the case of a chronic or progressive disability, that enable the recipient to live at the recipient's highest level of independence; or

(3) provide treatment interventions for recipients who are progressing but not at a rate comparable to the expectations of restorative care.

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, delegated health services provided by therapy assistants must be provided under the supervision 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 or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law;

B. speech-language or audiology service that is provided without a written referral from a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law;

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 or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law 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 or a cognitive or psychological deficit;

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 program 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 144A.04; 144A.08; 256B.04; 256B.431*

History: *15 SR 2404; 20 SR 303; 26 SR 487; L 2011 1Sp11 art 3 s 12; 38 SR 246*

Published Electronically: *August 26, 2013*

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. Additionally, a physical therapist, occupational therapist, audiologist, or speech-language pathologist must be enrolled by Medicare.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404; 33 SR 847; 38 SR 246*

Published Electronically: *August 26, 2013*

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*

Published Electronically: *August 12, 2008*

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 in 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: *12 SR 624; 21 SR 525*

Published Electronically: *August 12, 2008*

9505.0405 [Repealed, 19 SR 2004]

Published Electronically: *August 12, 2008*

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*

Published Electronically: *August 12, 2008*

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*

Published Electronically: *August 12, 2008*

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, 9505.0410, 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 90 days. 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 in compliance with Code of Federal Regulations, title 42, chapter IV, subchapter G, part 485, subpart H, section 485.711.

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

(1) the recipient's medical and treatment 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 or other licensed practitioner of the healing arts.

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) documented evidence of progress at least 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; 38 SR 246*

Published Electronically: *August 26, 2013*

9505.0415 LONG-TERM CARE FACILITIES; LEAVE DAYS.

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

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

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

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

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

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

F. "Therapeutic leave" means the absence of a recipient from a long-term care facility, with the expectation of the recipient's return to the facility, to a camp meeting applicable licensure requirements of

the Minnesota Department of Health, a residential setting other than a long-term care facility, a hospital, or other entity eligible to receive federal, state, or county funds to maintain a recipient. Leave for a home visit or a vacation is a therapeutic leave.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. recipients receiving intermediate care facility, developmentally disabled services as provided in part 9505.0420, subpart 4, 72 leave days per calendar year. In addition to the number of leave days specified in this item, the commissioner may approve up to 48 additional therapeutic leave days per calendar year for family activities if:

(1) the recipient or recipient's legal representative requests additional therapeutic leave days;

(2) the case manager recommends that the leave is consistent with the goals of the recipient's individual service plan as defined in Minnesota Statutes, section 256B.092, subdivision 1b;

(3) an evaluation by the case manager shows that home and community-based services and other alternative services are not feasible; and

(4) all other state and federal requirements relating to therapeutic leave days are met;

D. recipients residing in a long-term care facility that has a license to provide services for persons with physical disabilities as provided in parts 9570.2000 to 9570.3400, 72 leave days per calendar year.

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

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

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

C. The long-term care facility charge for a leave day for a recipient must not exceed the charge for a leave day for a private paying resident. "Private paying resident" has the meaning given in Minnesota Statutes, section 256B.441, subdivision 32.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 19 SR 1227; L 2005 c 56 s 2; L 2014 c 262 art 5 s 6*

Published Electronically: *October 21, 2014*

9505.0420 LONG-TERM CARE FACILITY SERVICES.

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

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

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

B. nursing care as defined in Minnesota Statutes, section 144A.01, subdivision 6, that can be safely performed only by or under the direction of a registered nurse in compliance with parts 4655.0090 to 4655.9342; or

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

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

A. daily care ordered by the recipient's attending physician to be provided in compliance with parts 4655.0090 to 4655.9342;

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

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

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

B. requires care under the management of a qualified developmental disability professional; and

C. requires active treatment as defined in Code of Federal Regulations, title 42, section 435.1010.

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; L 2005 c 56 s 2; L 2013 c 59 art 3 s 21*

Published Electronically: *August 1, 2013*

9505.0425 RESIDENT FUND ACCOUNTS.

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

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

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

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

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

D. The facility shall require a recipient who withdraws $10 or more at one time to sign a receipt for the withdrawal. The facility shall retain the receipt and written records of the account until the account is

subjected to the field audit required under Minnesota Statutes, section 256B.35, subdivision 4. A withdrawal of $10 or more that is not documented by a receipt must be credited to the recipient's account. Receipts for the actual item purchased for the recipient's use may substitute for a receipt signed by the recipient.

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

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

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

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

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

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

A. Medical transportation as provided in part 9505.0315.

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

C. Laundering of the recipient's clothing as provided in Minnesota Statutes, section 256B.441, subdivision 22.

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; L 2014 c 262 art 5 s 6*

Published Electronically: *October 21, 2014*

9505.0430 HEALTH CARE INSURANCE PREMIUMS.

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 13, 2013*

9505.0440 MEDICARE BILLING REQUIRED.

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 12, 2008*

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.

A. For skilled nursing care facility services, the rates shall be as established in parts 9549.0010 to 9549.0080 and Minnesota Statutes, sections 256B.431, 256B.434, and 256B.441.

B. For intermediate care facility services, the rates shall be as established in parts 9549.0010 to 9549.0080 and Minnesota Statutes, sections 256B.501 to 256B.5013.

C. For services of an intermediate care facility for persons with developmental disability, the rates shall be as established in parts 9553.0010 to 9553.0080.

D. For hospital services, the rates shall be as established in parts 9500.1090 to 9500.1140.

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

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

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

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

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

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

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

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

M. For EPSDT services, 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.

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

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

P. For rural health clinic services, reimbursement shall be according to the methodology in Code of Federal Regulations, title 42, section 447.371. If a rural health clinic other than a provider

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

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

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

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

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

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

(3) The payment rate for bus, taxicab, and other commercial carriers must be the carrier's usual and customary fee for the service but must not exceed the department's maximum allowable payment for special transportation services.

(4) The payment rate for private automobile transportation must be the amount per mile allowed on the most recent federal income tax return for actual miles driven for business purposes.

(5) The payment rate for air ambulance transportation must be consistent with the level of medically necessary services provided during the recipient's transportation and must be the lowest of the medical assistance maximum allowable charge, the provider's usual and customary charge, the charge submitted by the provider, or the payment allowed by Medicare for a similar service. Payment for air ambulance transportation of a recipient not having a life threatening condition requiring air ambulance transportation shall be at the level of medically necessary services which would have been otherwise provided to the recipient at rates specified in subitems (1) to (4).

S. For medical supplies and equipment, the rates shall be the lowest of the provider's submitted charge, the Medicare fee schedule amount for medical supplies and equipment, or the amount determined as appropriate by use of the methodology set forth in this item. If Medicare has not established a reimbursement amount for an item of medical equipment or a medical supply, then the medical assistance payment shall be based upon the 50th percentile of the usual and customary charges submitted to the department for the item or medical supply for the previous calendar year minus 20 percent. For an item of medical equipment or a medical supply for which no information about usual and customary charges exists for a previous calendar year payments shall be based upon the manufacturer's suggested retail price minus 20 percent.

T. For prosthetics and orthotics, the rate shall be the lower of the Medicare fee schedule amount or the provider's submitted charge.

U. For health services for which items A to T do not provide a payment rate, the department may use competitive bidding, negotiate a rate, or establish a payment rate by other means consistent with statutes, federal regulations, and state rules.

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

History: *12 SR 624; L 1987 c 209 s 39; 16 SR 2518; L 2005 c 56 s 2; L 2014 c 262 art 5 s 6; L 2014 c 291 art 9 s 5*

Published Electronically: *October 21, 2014*

9505.0446 HOSPICE CARE PAYMENT RATES AND PROCEDURES.

Subpart 1. **Rate categories.** Providers of hospice care as described in part 9505.0297 are paid at one of four fixed daily rates that apply to each of the four categories of services in subpart 3. The fixed daily rates apply to all services, except for certain physician services as described in subpart 5, and room and board in a long-term care facility as described in subparts 6 and 7.

Subp. 2. **Long-term care facility as residence.** For purposes of this part, a recipient who resides in a long-term care facility is considered to live at home.

Subp. 3. **Categories of service.** Except as otherwise provided by subparts 4 to 6, no payments shall be made for specific services provided by the hospice. Fixed daily rates are calculated under subpart 4 for each of the following categories of services:

A. Routine home care day, which is a day on which a recipient who has elected to receive hospice care is at home and is not receiving continuous care as defined in item B.

B. Continuous home care day, which is a day on which a recipient who has elected to receive hospice care has not been admitted to a facility that provides inpatient care, except when a long-term care facility is the recipient's residence under subpart 2, and the recipient receives hospice care consisting of nursing services, including home health aide or homemaker services, on a continuous basis at home, as

provided by part 9505.0297, subpart 17. No fewer than eight hours a day of nursing care must be provided by a registered nurse or licensed practical nurse. Continuous home care may be furnished only during periods of crisis as described in part 9505.0297, subpart 17, and only as necessary to maintain the terminally ill recipient at home.

C. Inpatient respite care day, which is a day on which the recipient who has elected hospice care receives inpatient care in an inpatient facility certified for medical assistance on a short-term basis for respite. This item is subject to the limits provided by part 9505.0297, subpart 18. This item does not apply to a recipient whose residence is a long-term care facility under subpart 2.

D. General inpatient care day, which is a day on which a recipient who has elected hospice care receives general inpatient care in a hospital or skilled nursing facility that provides inpatient care for control of pain or management of acute or chronic symptoms that cannot be managed in other settings. This item does not apply to a recipient who receives inpatient care in a long-term care facility in which the recipient is a resident under subpart 2.

Subp. 4. **Payments and limitations.** Medical assistance will pay a hospice for each day a recipient is under the hospice's care. Payment is in the same amounts, uses the same methodology, and is subject to the same limits and cap amount used by Medicare under Code of Federal Regulations, title 42, sections 418.301 to 418.309, as amended through October 1, 1987, except that the inpatient day limit on both inpatient respite care days and general inpatient care days does not apply to recipients afflicted with acquired immunodeficiency syndrome (AIDS), as provided by United States Code, title 42, section 1396d(o)(1)(B). The rates are determined by the Centers for Medicare and Medicaid Services (CMS), United States Department of Health and Human Services, as provided by Code of Federal Regulations, title 42, section 418.306, as amended through October 1, 1987, and as adjusted by CMS for the Medicare copay amounts not allowed under medical assistance. Payments to long-term care facilities under subparts 6 and 7 are not included in the cap amount. Changes in rates are announced in the Federal Register. No payment will be made for bereavement counseling under part 9505.0297, subpart 19.

Subp. 5. **Payment for physician services.** Physician services are paid according to items A to C.

A. The services specified in subitems (1) and (2) are included in the rates provided by subpart 4:

(1) general supervisory services of the hospice's medical director; and

(2) participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the hospice's interdisciplinary group.

B. Other than for services described in item A, medical assistance shall pay the hospice for physician services furnished by physicians who are employees of the hospice or who provide services under arrangements with the hospice, at the rate provided by part 9505.0445, item E. Payment for these physician services is included in the amount subject to the cap amount in subpart 4. No payment will be made to the hospice for services donated by physicians who are employees of the hospice or who provide services under arrangements with the hospice.

C. Services of the recipient's attending physician, if the physician is not an employee of the hospice or is not providing services under arrangements with the hospice, are not considered hospice services and are not included in the amount subject to the cap amount in subpart 4. These services are reimbursed according to parts 9505.0345 and 9505.0445, item E.

Subp. 6. **Payment for room and board in long-term care facilities.** If a recipient resides in a long-term care facility under subpart 2 that is certified as a medical assistance provider and the recipient has elected medical assistance coverage of hospice services, the long-term care facility shall not be paid by medical assistance under parts 9549.0010 to 9549.0080, but shall be paid by the hospice at a rate negotiated by the long-term care facility and the hospice.

Subp. 7. **Payment to hospice for residents of long-term care facilities.** The commissioner shall establish the payments to hospices for the room and board of medical assistance recipients who reside in long-term care facilities certified by medical assistance, as provided by items A and B.

A. The daily room and board payment rate shall be either:

(1) 83 percent of the long-term care facility's daily payment rate for the recipient's resident class, as determined under parts 9549.0010 to 9549.0080; or

(2) 83 percent of the long-term care facility's daily payment rate for the recipient's certification level, if the long-term care facility is not subject to parts 9549.0010 to 9549.0080.

B. The payment to the hospice is the product of the hospice's daily room and board payment rate determined in item A and the number of days for which the recipient resides in the long-term care facility in the month, less the recipient's spend down amount for that month under part 9505.0065, subpart 11, item F.

Statutory Authority: *MS s 256B.02*

History: *13 SR 1861; L 2002 c 277 s 32*

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9505.0450 BILLING PROCEDURES; GENERAL.

Subpart 1. **Billing for usual and customary fee.** A provider shall bill the department for the provider's usual and customary fee only after the provider has provided the health service to the recipient.

Subp. 2. **Time requirements for claim submission.** Except as in subpart 4, a provider shall submit a claim for payment no later than 12 months after the date of service to the recipient and shall submit a request for an adjustment to a payment no later than six months after the payment date. The department has no obligation to pay a claim or make an adjustment to a payment if the provider does not submit the claim within the required time.

Subp. 3. **Retroactive billing.** If the recipient is retroactively eligible for medical assistance and notifies the provider of the retroactive eligibility, the provider may bill the department the provider's usual and customary charge. If the recipient paid any portion of the provider's usual and customary charge during this period, the provider must reimburse the recipient the actual amount paid by the recipient but not more than the amount paid to the provider by medical assistance. Failure of the provider to comply with this part shall not be appealable by the recipient under Minnesota Statutes, section 256.045.

Subp. 4. **Exceptions to time requirements.** A provider may submit a claim for payment more than 12 months after the date of service to the recipient if one of the circumstances in items A to D exists. The department shall pay the claim if it satisfies the other requirements of a claim for a covered service.

A. The medical assistance claim was preceded by a claim for payment under Medicare which was filed according to Medicare time limits. To be eligible for payment, the claim must be presented to the department within six months of the Medicare determination.

B. Medical assistance payment of the claim is ordered by the court and a copy of the court order accompanies the claim or an appeal under Minnesota Statutes, section 256.045, is upheld. To be eligible for payment, the claim must be presented within six months of the court order.

C. The provider's claim for payment was rejected because the department received erroneous or incomplete information about the recipient's eligibility. To be eligible for payment, the provider must resubmit the claim to the department within six months of the erroneous determination, together with a copy of the original claim, a copy of the corresponding remittance advice, and any written communication the provider has received from the local agency about the claim. The local agency must verify to the department the recipient's eligibility at the time the recipient received the service.

D. The provider's claim for payment was erroneously rejected by the department. To be eligible for payment, the provider must resubmit the claim within six months of receipt of the notice of the erroneous determination by sending the department a copy of the original claim, a copy of the remittance advice, any written communication about the claim sent to the provider by the local agency or department, and documentation that the original claim was submitted within the 12-month limit in subpart 2.

Subp. 5. **Format of claims.** To be eligible for payment, a provider must enter on the claim the diagnosis and procedure codes required by the department and submit the claim on forms or in the format specified by the department. The provider must include with the claim information about a required prior authorization or second surgical opinion. Further, the provider shall submit with the claim additional records or reports requested by the department as necessary to determine compliance with parts 9505.0170 to 9505.0475.

Subp. 6. **Repeated submission of nonprocessible claims.** A provider's repeated submission of claims that cannot be processed without obtaining additional information shall constitute abuse and shall be subject to the sanctions available under parts 9505.2160 to 9505.2245.

Subp. 7. **Direct billing by provider.** Except as in parts 9505.0070 and 9505.0440, a provider or the provider's business agent as in part 9505.0455 shall directly bill the department for a health service to a recipient.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

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9505.0455 BILLING PROCEDURE; BUSINESS AGENT.

A health service rendered by a provider may be billed by the provider's business agent, if the business agent's compensation is related to the actual cost of processing the billing; is not related on a percentage or other basis to the amount that is billed; and is not dependent upon collection of the payment.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

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9505.0460 CONSEQUENCES OF A FALSE CLAIM.

A provider who wrongfully obtains a medical assistance payment is subject to Minnesota Statutes, sections 256B.064, 256B.121, 609.466, and 609.52; United States Code, title 42, section 1320a-7b; and parts 9505.2160 to 9505.2245.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

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9505.0465 RECOVERY OF PAYMENT TO PROVIDER.

Subpart 1. **Department obligations to recover payment.** The department shall recover medical assistance funds paid to a provider if the department determines that the payment was obtained fraudulently or erroneously. Monetary recovery under the medical assistance program is permitted for the following:

A. intentional and unintentional error on the part of the provider or state or local welfare agency;

B. failure of the provider to comply fully with all authorization control requirements, prior authorization procedures, or billing procedures;

C. failure to properly report third-party payments; and

D. fraudulent or abusive actions on the part of the provider.

Subp. 2. **Methods of monetary recovery.** The monetary recovery may be made by withholding current payments due the provider, by demanding that the provider refund amounts so received as provided in part 9505.1950, or by any other legally authorized means.

Subp. 3. **Interest charges on monetary recovery.** If the department allows the provider to repay medical assistance funds by installment payments, the provider must pay interest on the funds to be recovered. The interest rate shall be the rate established by the Department of Revenue under Minnesota Statutes, section 270C.40.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; L 2005 c 151 art 1 s 116*

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9505.0470 PROVIDER RESPONSIBILITY FOR BILLING PROCEDURE.

For the purposes of parts 9505.0170 to 9505.0475 and 9505.1760 to 9505.2150, a provider is responsible for all medical assistance payment claims submitted to the department for health services furnished by the provider or the provider's designee to a recipient regardless of whether the claim is submitted by the provider or the provider's employee, vendor, or business agent, or an entity who has a contract with the provider.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

Published Electronically: *August 12, 2008*

9505.0475 SUSPENSION OF PROVIDER CONVICTED OF CRIME RELATED TO MEDICARE OR MEDICAID.

Subpart 1. **Crime related to Medicare.** A provider convicted of a crime related to the provision, management, or administration of health services under Medicare is suspended from participation under the medical assistance program. The effective date of the suspension is the date established by the Department of Health and Human Services; the period of suspension is the period established by the Department of Health and Human Services.

Subp. 2. **Crime related to medical assistance.** A provider convicted of a crime related to the provision, management, or administration of health services under medical assistance is suspended from participation under the medical assistance program. The effective date of suspension is the date of conviction. The period of suspension is the period of any sentence imposed by the sentencing court, even if the sentence is suspended or the provider is placed on probation. A provider is provisionally suspended upon conviction and pending sentencing.

Subp. 3. **Definition of "convicted."** "Convicted" for purposes of this part means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from the judgment is pending, and includes a plea of guilty or nolo contendere.

Subp. 4. **Suspension after conviction of person with ownership interest.** This part also applies to and results in the suspension of any provider when a person who has an ownership or control interest in the provider, as defined and determined by Code of Federal Regulations, title 42, sections 455.101 and 455.102, is convicted of a crime related to medical assistance. A provider suspended under this subpart may seek reinstatement at the time the convicted person ceases to have any ownership or control interest in the provider.

Subp. 5. **Notice of suspension.** The commissioner shall notify a provider in writing of suspension under this part. The notice shall state the reasons for the suspension, the effective date and duration of the suspension, and the provider's right to appeal the suspension.

Subp. 6. **Right to appeal.** A provider suspended under this part may file an appeal pursuant to Minnesota Statutes, section 256B.064, and part 9505.2150. The appeal shall be heard by an administrative law judge according to Minnesota Statutes, sections 14.48 to 14.56. Unless otherwise decided by the commissioner, the suspension remains in effect pending the appeal.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624*

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9505.0476 [Repealed, 17 SR 1448; 17 SR 1454]

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9505.0491 Subpart 1. [Repealed, 17 SR 1448; 17 SR 1454]

Subp. 2. [Repealed, 17 SR 1448; 17 SR 1454]

Subp. 3. [Repealed, 17 SR 1448; 17 SR 1454]

Subp. 4. [Repealed, 17 SR 1448; 17 SR 1454]

Subp. 5. [Repealed, 17 SR 1448; 17 SR 1454]

Subp. 6. [Repealed, 17 SR 1448; 17 SR 1454]

Subp. 7. [Repealed, 30 SR 1318]

Subp. 8. [Repealed, 30 SR 1318]

Subp. 9. [Repealed, 17 SR 1448; 17 SR 1454]

Subp. 10. [Repealed, 17 SR 1448; 17 SR 1454]

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9505.0500 [Repealed, 23 SR 298]

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HOSPITAL ADMISSIONS CERTIFICATION

9505.0501 SCOPE.

Parts 9505.0501 to 9505.0545 establish the standards and procedures for admission certification to be followed by admitting physicians and hospitals seeking payment under parts 9500.1090 to 9500.1140 for inpatient hospital services provided to medical assistance, general assistance medical care, and MinnesotaCare recipients under Minnesota Statutes, chapters 256B and 256D, and section 256L.03, subdivision 3, paragraph (b). Parts 9505.0501 to 9505.0545 are to be read in conjunction with Code of Federal Regulations, title 42, and titles XVIII and XIX of the Social Security Act, United States Code, title 42, chapter 7, subchapters XVIII and XIX. The department retains the authority to approve prior authorizations established under parts 9505.5000 to 9505.5030 and second medical opinions established under parts 9505.5035 to 9505.5105 in addition to admission certification.

Statutory Authority: *MS s 256.9353; 256B.04; 256D.03*

History: *23 SR 298*

Published Electronically: *January 14, 2010*

9505.0505 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9505.0501 to 9505.0545, the following terms have the meanings given them.

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

Subp. 3. **Admission certification.** "Admission certification" means the determination of the medical review agent that all or part of a recipient's inpatient hospital services are medically necessary and that medical assistance, general assistance medical care, or MinnesotaCare funds may be used to pay the admitting physician, hospital, and other vendors of inpatient hospital services for providing medically necessary services, subject to parts 9500.1090 to 9500.1140; 9505.0170 to 9505.0475; 9505.1000 to 9505.1040; and 9505.5000 to 9505.5105.

Subp. 4. **Admitting physician.** "Admitting physician" means the physician who orders the recipient's admission to the hospital.

Subp. 5. **Certification number.** "Certification number" means the number issued by the medical review agent that establishes that all or part of a recipient's inpatient hospital services are medically necessary.

Subp. 6. **Commissioner.** "Commissioner" means the commissioner of human services or an authorized representative of the commissioner.

Subp. 7. **Concurrent review.** "Concurrent review" means a review and determination performed while the recipient is in the hospital and focused on the medical necessity of inpatient hospital services. The review consists of admission review, continued stay review, and, when appropriate, procedure review.

Subp. 8. **Continued stay review.** "Continued stay review" means a review and determination, after the admission certification, of the medical necessity of continued inpatient hospital services to the recipient.

Subp. 9. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 10. **Diagnostic categories.** "Diagnostic categories" means the diagnostic classifications established under Minnesota Statutes, section 256.969, subdivision 2.

Subp. 11. **Diagnostic category validation.** "Diagnostic category validation" means the process of comparing the medical record to the information submitted on the inpatient hospital billing form to ascertain the accuracy of the information upon which the diagnostic category was assigned.

Subp. 12. **Emergency.** "Emergency" has the meaning given in part 9505.0175, subpart 11.

Subp. 13. **General assistance medical care or GAMC.** "General assistance medical care" or "GAMC" means the program established by Minnesota Statutes, section 256D.03.

Subp. 14. **Hospital.** "Hospital" means a facility defined in Minnesota Statutes, section 144.696, subdivision 3, and licensed under Minnesota Statutes, sections 144.50 to 144.58, or an out-of-state facility licensed to provide acute care under the requirements of the state in which it is located or an Indian health service facility designated by the federal government to provide acute care.

Subp. 15. **Inpatient hospital service.** "Inpatient hospital service" means a service provided by or under the supervision of a physician after admission to a hospital and furnished in the hospital, including outpatient services provided by the same hospital that immediately precede the admission.

Subp. 16. **Medical assistance or MA.** "Medical assistance" or "MA" means the program established under title XIX of the Social Security Act, United States Code, title 42, chapter 7, subchapter XIX, and Minnesota Statutes, chapter 256B. For purposes of parts 9505.0501 to 9505.0545, "medical assistance" includes general assistance medical care and MinnesotaCare unless otherwise specified.

Subp. 17. **Medical record.** "Medical record" means the information required in part 9505.2175, subpart 2.

Subp. 18. **Medical review agent.** "Medical review agent" means the representative of the commissioner who is authorized by the commissioner to administer procedures for admission certifications, medical record reviews and reconsideration, and perform other functions as stipulated in the terms of the agent's contract with the department.

Subp. 19. **Medically necessary.** "Medically necessary" means an inpatient hospital service that is consistent with the recipient's diagnosis or condition, and under the criteria in part 9505.0530 cannot be provided on an outpatient or other basis.

Subp. 20. **Medicare.** "Medicare" means the federal health insurance program for the aged and disabled under title XVIII of the Social Security Act, United States Code, title 42, chapter 7, subchapter XVIII.

Subp. 21. **MinnesotaCare.** "MinnesotaCare" means the program established in Minnesota Statutes, section 256L.02.

Subp. 22. **Physician.** "Physician" means a person licensed to provide services within the scope of the profession as defined in Minnesota Statutes, chapter 147.

Subp. 23. **Physician adviser.** "Physician adviser" means a physician who practices in the specialty area of the recipient's admitting or principal diagnosis or a specialty area related to the admitting or principal diagnosis.

Subp. 24. **Prior authorization.** "Prior authorization" means the prior approval for medical services by the department as required under Minnesota Statutes, sections 256.9353, subdivisions 1 and 3, and 256B.0625, subdivision 25, and applicable rules adopted by the commissioner.

Subp. 25. **Principal diagnosis.** "Principal diagnosis" means the condition established, after study, as the reason for the admission of the recipient to the hospital for inpatient hospital services.

Subp. 26. **Principal procedure.** "Principal procedure" means a procedure performed for definitive treatment of the recipient's principal diagnosis rather than one performed for diagnostic or exploratory purposes or a procedure necessary to take care of a complication. When multiple procedures are performed for definitive treatment, the principal procedure is the procedure most closely related to the principal diagnosis.

Subp. 27. **Provider.** "Provider" means an individual or organization under an agreement with the department to furnish health services to persons eligible for the medical assistance, MinnesotaCare, or general assistance medical care programs.

Subp. 28. **Provider number.** "Provider number" means a number issued by the department to a provider who has signed a provider agreement under part 9505.0195.

Subp. 29. **Readmission.** "Readmission" means an admission that occurs within 15 days of a discharge of the same recipient. The 15-day period does not include the day of discharge or the day of readmission.

Subp. 30. **Recertification.** "Recertification" means the procedure by which a physician, or physician assistant or nurse practitioner acting within the scope of practice as defined by state law and under supervision of a physician, authorizes a recipient's continued need for inpatient hospital services as required by federal regulations. An admission must be recertified for every 60 days of continuous hospitalization

of a recipient beginning from the date of the admission and must be documented in the medical record. Recertification does not apply to general assistance medical care or MinnesotaCare recipients.

Subp. 31. **Recipient.** "Recipient" means a person who is eligible for the medical assistance, general assistance medical care, or MinnesotaCare program.

Subp. 32. **Recipient ID number.** "Recipient ID number" means the unique eight digit identification number assigned to a recipient who has been determined eligible for medical assistance, general assistance medical care, or MinnesotaCare.

Subp. 33. **Reconsideration.** "Reconsideration" means a review of a denial or withdrawal of admission certification according to part 9505.0520, subparts 9, 9b, and 9c.

Subp. 34. **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, verifying recertification, where applicable, 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. 35. **Transfer.** "Transfer" means the movement of a patient after admission from one hospital directly to another hospital or to or from a unit of a hospital recognized as a rehabilitation distinct part by Medicare as provided by Minnesota Statutes, section 256.969, subdivision 12.

Statutory Authority: *MS s 256.9353; 256B.04; 256D.03*

History: *23 SR 298*

Published Electronically: *January 14, 2010*

9505.0510 [Repealed, 23 SR 298]

Published Electronically: *August 12, 2008*

9505.0515 MEDICAL REVIEW AGENT'S QUALIFIED STAFF.

The medical review agent must provide professional and technical expertise to conduct the hospital admission certification program for medical assistance, general assistance medical care, and the MinnesotaCare programs. Unless otherwise specified in parts 9505.0501 to 9505.0545, the professional and technical expertise must consist of persons who are licensed physicians or who are registered nurses licensed under Minnesota Statutes, sections 148.171 to 148.285, to practice professional nursing and who are qualified by training and experience to review the medical necessity of admissions.

Statutory Authority: *MS s 256.9353; 256B.04; 256D.03*

History: *23 SR 298*

Published Electronically: *August 12, 2008*

9505.0520 INPATIENT ADMISSION CERTIFICATION.

Subpart 1. **Requirement for admission certification.** Except as provided in subpart 2, a hospital or admitting physician furnishing inpatient hospital services to a recipient must obtain admission certification in order for the admitting physician, the hospital, or other provider of an inpatient hospital service to receive medical assistance payment for the inpatient hospital services to the recipient.

A. Admission certification must be obtained when a recipient is admitted, readmitted, or transferred to a hospital unless the admission is combined under the readmission criteria of part 9505.0540.

B. An admission certification number is valid only for the hospital admission for which it is issued, except in circumstances specified in part 9505.0540.

C. Admission certification for the admission of a MinnesotaCare recipient must be requested within 30 days of the date of admission or be subject to penalties under Minnesota Statutes, section 256L.03, subdivision 3, paragraph (b).

Subp. 2. **Exclusions from admission certification.** Admissions for inpatient hospital services under items A to C shall be excluded from the requirement in subpart 1. The admissions are subject to retrospective review as stated in subpart 10.

A. The admission of a pregnant woman that results in the delivery of a newborn or a stillbirth, and the admission of a newborn resulting from birth.

B. The admission is for Medicare Part A covered inpatient hospital services which are provided to a recipient who is also eligible for medical assistance and for which medical assistance payment is requested for the coinsurance and deductible payments only.

C. An admission to a hospital that is not located in Minnesota or the local trade area for which a prior authorization has been obtained according to parts 9505.5000 to 9505.5030.

Subp. 3. **Admitting physician and hospital responsibilities.** The admitting physician or hospital that seeks medical assistance payment for inpatient hospital services provided to a recipient must follow the procedures in items A to C.

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

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

(2) recipient's name, recipient ID number, sex, and date of birth;

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

(4) primary procedure, or principal procedure, when applicable, according to the most recent edition of Current Procedural Terminology published by the American Medical Association or the International Classification of Diseases – Clinical Modification, published by the Practice Management Information Corporation, 4727 Wilshire Boulevard, Los Angeles, CA 90010 which are incorporated by reference. These books are available through the Minitex interlibrary loan system and are subject to change;

(5) date of admission, or expected date of admission;

(6) whether the admission is a readmission or a transfer;

(7) admitting diagnosis, or principal diagnosis, when applicable, according to the most recent edition of the International Classification of Diseases – Clinical Modification; and

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

B. Inform all providers involved in the recipient's inpatient hospital services of the certification number.

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

Subp. 4. [Repealed, 23 SR 298]

Subp. 5. [Repealed, 23 SR 298]

Subp. 6. [Repealed, 23 SR 298]

Subp. 7. **Ineligibility to serve as physician or physician adviser.** A physician shall not be eligible to determine the medical necessity of an admission under parts 9505.0501 to 9505.0545 if:

A. the physician is the admitting physician for the admission for which certification is being requested;

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

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

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

Subp. 8. **Procedure for admission certification.** The procedures for admission certification are listed in items A to I.

A. Upon receipt of the information requested in subpart 3, item A, the medical review agent shall review the information and determine whether the admission is medically necessary.

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

C. If the medical review agent is unable to determine that the admission is medically necessary, the medical review agent shall contact a physician.

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

E. If the physician determines that the admission is not medically necessary or is unable to determine that the admission is medically necessary, the medical review agent shall notify the provider by telephone, and the provider may request within 24 hours of the medical review agent's notification, exclusive of weekends and holidays, a second physician's opinion.

F. If the provider requests a second physician's opinion, the medical review agent shall contact a second physician. If the second physician determines that the admission is medically necessary, the medical review agent shall issue a certification number.

G. If the second physician determines that the admission is not medically necessary, or is unable to determine that the admission is medically necessary, or if the provider does not request a second physician's opinion when the first physician determines that the admission is not medically necessary or is unable to determine that the admission is medically necessary, then the medical review agent shall deny the admission certification and shall not issue a certification number.

H. The medical review agent shall make the determination about medical necessity and inform the provider by telephone within 24 hours of the receipt of the information requested in subpart 3, item A, exclusive of weekends and holidays, unless the provider requests a second physician's opinion. If the

provider requests a second physician's opinion, the medical review agent shall make the determination of medical necessity and notify the provider by telephone within 24 hours of the request, exclusive of weekends and holidays. The medical review agent shall send a written notice of the determination to the hospital and admitting physician within five working days of the determination. In the case of a denial, the written notices to the hospital and the admitting physician required under this item must be sent by certified mail. The denial notices to the admitting physician and hospital must state the reasons for the denial and inform the admitting physician or hospital that a reconsideration may be requested under subpart 9. In the case of a denial when the recipient has not received the inpatient hospital services, the medical review agent shall send a written notice of the denial to the recipient within five working days of the determination. The denial notice to the recipient must state the recipient's right of appeal under part 9505.0545 and Minnesota Statutes, section 256.045.

I. When there is a need to further substantiate the medical necessity of the admission, the department or medical review agent may request that the provider submit, at the provider's expense, a copy of the recipient's medical record or part of the medical record needed to make the determination. If the provider fails to submit a requested record within 30 days of the date of the request, the department or the medical review agent shall make a determination based on the information available.

Subp. 9. **Reconsideration requested.** The admitting physician or the hospital may request reconsideration of a decision to deny or withdraw an admission certification if:

A. the medical review agent denies an admission certification number because the admission is not medically necessary;

B. the medical review agent withdraws an admission certification number for all or part of a recipient's stay because all or part of the stay was not medically necessary based on a concurrent or retrospective review; or

C. the medical review agent denies or withdraws an admission certification number or considers an admission and readmission to be a transfer under the readmission criteria in part 9505.0540 because the admission and readmission meet the criteria specified in part 9505.0540.

The admitting physician or the hospital shall submit a written request for reconsideration to the medical review agent within 30 days of the date of receipt of the certified letter from the medical review agent denying or withdrawing the admission certification number. The request must include the recipient's name and the recipient's ID number; the disputed admission; the reason for the dispute; the medical record or the part of the medical record needed to make a determination of the medical necessity of the admission or appropriateness of a readmission and any other information related to the admission and determination; and the name, address, and telephone number of the person to contact about the reconsideration.

Subp. 9a. [Repealed, 23 SR 298]

Subp. 9b. **Reconsideration; physician advisers appointed by medical review agent.** Upon receipt of a request for reconsideration under subpart 9, the medical review agent shall appoint at least three physician advisers who did not take part in the decision to deny or withdraw all or part of the admission certification. Each physician adviser shall determine the medical necessity of the admission or the continued stay or, in the case of a readmission, determine whether the admission and readmission meet the criteria in part 9505.0540. The reconsideration decision must be the majority opinion of the physician advisers. In making the decision, the three physician advisers shall use the criteria of medical necessity set out in part 9505.0530.

Subp. 9c. **Completion of reconsideration.** The medical review agent shall complete the reconsideration requested under subpart 9 within 60 days of receipt of the information required under subpart 9. The medical review agent shall notify the provider who requested the reconsideration, by telephone, of the decision within 24 hours of receipt of the physician adviser's determination, exclusive of weekends and holidays. A written notice of the decision must be sent by certified mail to the hospital and the admitting physician by the medical review agent within ten working days of the receipt of the physician adviser's determination. In the event a denial is upheld, the notice must inform the admitting physician and hospital of the right to request an appeal of the reconsideration decision within 30 days of receiving the notice according to Minnesota Statutes, section 256.9685, subdivisions 1b to 1d.

Subp. 10. **Medical record review and determination after admission.** The department or the medical review agent may conduct a concurrent, continued stay or retrospective review of a recipient's medical record to establish the recipient's diagnosis and procedure codes and to determine whether the recipient's admission and all the inpatient hospital services provided to the recipient were medically necessary, whether a continued stay was medically necessary or will be medically necessary, and whether all medically necessary inpatient hospital services were provided to the recipient. In making a determination under this subpart, the medical review agent must follow the procedure in items A to G.

A. The medical review agent shall review the medical record to establish the diagnosis and procedure codes for diagnostic category validation. Additionally, the medical review agent may review the bills, invoices, and all supporting documentation pertaining to a request for medical assistance payment.

B. The medical review agent may request additional information from the admitting physician or the hospital as necessary to clarify the medical record if the medical review agent is unable to determine that the recipient's admission was medically necessary, that all inpatient hospital services provided to the recipient were medically necessary, that the recipient's continued stay was medically necessary or will be medically necessary, or that all medically necessary inpatient hospital services were provided. The additional information must be submitted at the expense of the admitting physician or hospital.

C. If, after additional information is submitted, the medical review agent is unable to determine that the recipient's admission was medically necessary, that the recipient's continued stay was medically necessary or will be medically necessary, or that all medically necessary inpatient hospital services were provided, the medical review agent must consult a physician.

D. If a physician determines that the recipient's admission was not medically necessary, or that all medically necessary inpatient hospital services were not provided, the medical review agent shall withdraw the previously issued certification number and shall notify the admitting physician and hospital of the determination by certified letter mailed within five working days. The notice shall state the right of the admitting physician and hospital to request a reconsideration under subpart 9.

E. If a physician determines that the recipient's continued stay was not medically necessary or will not be medically necessary, the portion of the stay determined not to be medically necessary will be denied. If the recipient is still an inpatient, the medical review agent shall notify the admitting physician and hospital of the determination by telephone within 24 hours of receipt of the determination, exclusive of weekends and holidays, and by certified letter mailed within five working days of receipt of the determination. If the recipient has been discharged, the medical review agent shall notify the admitting physician and hospital of the determination by certified letter mailed within five working days of receipt of the determination. The notice must state the right of the admitting physician and hospital to request a reconsideration under subpart 9.

F. If recertification of a recipient's need for inpatient hospital services was required but was not documented in the medical record, the medical review agent shall deny that portion of the admission that was not recertified.

G. If the medical review agent is unable to determine from the documentation in the recipient's medical records the reasons for the recipient's discharge and readmission according to criteria in part 9505.0540, the medical review agent shall submit the medical records of the recipient's admission and readmission to a physician. The physician shall review the records and determine the nature of the discharge and readmission according to the criteria in part 9505.0540, 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 and hospital by certified letter mailed within five working days. The notice must state the right of the admitting physician and hospital to request a reconsideration under subpart 9.

Subp. 11. **Payment adjustments.** The department may make payment adjustments according to the circumstances in items A to E.

A. For hospitals receiving payments under parts 9500.1090 to 9500.1140, and admitting physicians and other providers of inpatient hospital services receiving payments through medical assistance, if the admission was not medically necessary or the medical record does not adequately document that the admission was medically necessary, the entire payment shall be denied or recovered. If the hospital, admitting physician, and other providers of inpatient hospital services failed to provide inpatient hospital services that were medically necessary, the department may take action under parts 9505.2160 to 9505.2245.

B. For hospitals receiving payments under parts 9500.1090 to 9500.1140, and admitting physicians and other providers of inpatient hospital services receiving payments through medical assistance, if the admission was medically necessary but some or all of the additional inpatient hospital services were not or will not be medically necessary, or the medical record does not adequately document that the additional inpatient hospital services were or will be medically necessary, payment for the additional services shall be denied or recovered. If the hospital, admitting physician, and other providers of inpatient hospital services failed to provide inpatient hospital services that were medically necessary, the department may take action under parts 9505.2160 to 9505.2245.

C. If the diagnostic category validation indicates a discrepancy between the diagnostic category assigned to the claim and the diagnostic category established from the medical record, the department shall adjust the payment as applicable to the diagnostic category that is accurate for the recipient's condition according to the medical record.

D. If, within 30 days, 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, all or part of the payment shall be denied or recovered as provided in items A to C.

E. The provider may not seek payment from the recipient for inpatient hospital services provided under parts 9505.0501 to 9505.0545 if the certification number is not issued or is withdrawn.

Subp. 12. [Repealed, 23 SR 298]

Subp. 13. [Repealed, 23 SR 298]

Subp. 14. [Repealed, 23 SR 298]

Subp. 15. [Repealed, 23 SR 298]

Statutory Authority: *MS s 256.0625; 256.9353; 256.991; 256B.04; 256B.503; 256D.03*

History: *9 SR 2296; 11 SR 1687; 13 SR 1688; 20 SR 2405; 23 SR 298*

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9505.0521 [Repealed, 23 SR 298]

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9505.0522 [Repealed, 23 SR 298]

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9505.0530 INCORPORATION BY REFERENCE OF CRITERIA TO DETERMINE MEDICAL NECESSITY.

Subpart 1. **Determinations using medical necessity criteria.** The medical review agent shall follow the medical necessity criteria specified in subparts 2 and 3 in determining the following:

A. whether a recipient's admission is medically necessary;

B. whether the inpatient hospital services provided to the recipient were medically necessary;

C. whether the recipient's continued stay was or will be medically necessary; and

D. whether all medically necessary inpatient hospital services were provided to the recipient.

Subp. 2. **Criteria for inpatient hospital admission; general.** The most recent edition of the Appropriateness Evaluation Protocol of the National Institutes of Health is incorporated by reference. The book was published in 1984 by the Health Data Institute, 20 Maguire Road, Lexington, Massachusetts, 02173, and it is available through the Minitex interlibrary loan system. The book is not subject to change.

Subp. 3. **Criteria for inpatient psychiatric treatment.** The Criteria for Inpatient Psychiatric Treatment, 1981 edition, revised 1991, published by Blue Cross and Blue Shield of Minnesota are incorporated by reference. The criteria are available at Blue Cross and Blue Shield of Minnesota, P.O. Box 64560, Saint Paul, Minnesota 55164, and at the State Law Library, Minnesota Judicial Center, 25 Rev. Dr. Martin Luther King Jr. Blvd., Saint Paul, Minnesota 55155. The criteria are not subject to frequent change.

Statutory Authority: *MS s 256.9353; 256B.04; 256B.503; 256D.03*

History: *9 SR 2296; 11 SR 1687; 13 SR 1688; 23 SR 298*

Published Electronically: *August 12, 2008*

9505.0540 CRITERIA FOR READMISSIONS.

Subpart 1. [Repealed, 23 SR 298]

Subp. 2. [Repealed, 23 SR 298]

Subp. 3. **Readmission considered as a second admission.** The medical review agent shall issue a certification number for a readmission that meets the criteria for medical necessity specified in part 9505.0530, whether the admitting and readmitting hospitals are the same or different. The medical record of the admission must state why the recipient was discharged from the hospital and what the recipient's

medical status was upon discharge, and the medical record of the readmission must state why the recipient is being readmitted and what the recipient's medical status is at readmission. Both the admission and the readmission shall be subject to a retrospective review as provided in part 9505.0520, subpart 10. If the reason for the discharge and the reason for the readmission meet one set of circumstances specified in items A to D, the medical review agent shall determine that both the admission and the readmission shall retain the certification number subject to the hospitals' and admitting physicians' compliance with all requirements of parts 9505.0501 to 9505.0545.

A. The readmission results from the recipient leaving the hospital against medical advice.

B. The readmission results from the recipient being noncompliant with medical advice that is recorded on the recipient's medical record as being given to the recipient at the admitting hospital. For purposes of this part, "recipient being noncompliant with medical advice" means that the recipient, fully informed of his or her medical condition, and fully understanding the need for the treatment and the follow-up discharge instructions, if any, refuses to adhere to the treatment or to follow the discharge instructions.

C. The readmission results from a new episode of the same diagnosis of an episodic illness or condition.

D. The readmission results from the fact that the recipient's discharge from the admitting hospital and readmission are medically necessary according to prevailing medical standards, practice, and usage.

Subp. 4. **Readmission considered as continuous with admission.** The medical review agent shall determine that a readmission of a recipient is continuous with the recipient's admission whether the admitting and readmitting hospitals are the same or different if the circumstances requiring the recipient's readmission meet one set of the circumstances specified in items A to C. The medical review agent shall issue a certification number if the readmission meets the criteria for medical necessity specified in part 9505.0530. The medical record of the admission must state why the recipient was discharged from the hospital and what the recipient's medical status was upon discharge, and the medical record of the readmission must state why the recipient is being readmitted and what the recipient's medical status is at readmission. Both the admission and the readmission are subject to a retrospective review as provided in part 9505.0520, subpart 10. Upon completing the retrospective review and determining whether the readmission and admission are consistent with item A, B, or C, the medical review agent shall take the action specified in the item that applies. Medical assistance payment for the inpatient hospital services retaining the certification number after the determination resulting from the retrospective review must be paid according to parts 9500.1090 to 9500.1140 for the diagnostic category assigned to the recipient's principal diagnosis of the admission and readmission. In each circumstance, retention of the certification number is subject to the hospital's and admitting physician's compliance with all requirements of parts 9505.0501 to 9505.0545.

A. The recipient was discharged from the admitting hospital without receiving the procedure or treatment of the condition diagnosed during the admission because of the hospital's or physician's preference or because of a scheduling conflict. If the admitting and readmitting hospitals are the same, the medical review agent shall withdraw the certification number of the readmission and determine the admission eligible to retain the certification number. If the admitting and readmitting hospitals are not the same, the medical review agent shall apply the requirements under subpart 5, item C, regarding admission and readmission eligible for a transfer payment.

B. The recipient's discharge was not appropriate according to prevailing medical standards, practice, and usage. If the admitting and readmitting hospitals are the same, the medical review agent shall determine the admission eligible to retain the certification number and withdraw the certification number of the readmission. If the admitting and readmitting hospitals are different, the medical review agent shall withdraw the certification number of the admission and shall determine the readmission eligible to retain a certification number.

C. The recipient's discharge and readmission to the same hospital results from the preference of the recipient or the recipient's family that the recipient's treatment be delayed, that the recipient be discharged without receiving the necessary procedure or treatment, and that the recipient be readmitted for the necessary procedure or treatment. If the admitting and readmitting hospitals are the same, the medical review agent shall determine the admission eligible to retain the certification number and withdraw the certification number of the readmission. If the admitting and readmitting hospitals are not the same, the medical review agent shall apply the requirements under subpart 5, item A, regarding admission and readmission eligible for a transfer payment. For purposes of this part, "preference of the recipient or the recipient's family" means that the recipient or the recipient's family makes a choice to delay or change the location of inpatient hospital services, and the choice is compatible with prevailing medical standards, practices, and usage.

Subp. 5. **Admission and readmission eligible for transfer payment.** The medical review agent shall issue a certification number for an admission and readmission that are eligible for a transfer payment if the admission and readmission meet the criteria for medical necessity specified in part 9505.0530, and a set of circumstances in item A, B, or C. The medical record of the admission must state why the recipient was discharged from the hospital and what the recipient's medical status was upon discharge, and the medical record of the readmission must state why the recipient is being readmitted and what the recipient's medical status is at readmission. The medical review agent shall conduct a retrospective review of the medical records, determine whether the admission and readmission are consistent with the circumstances in item A, B, or C, and take the action specified in the item. Retention of the certification number by the hospital is also subject to the admitting physician's and hospital's compliance with all requirements of parts 9505.0501 to 9505.0545.

A. The readmission results from the preference of the recipient or the recipient's family that the recipient be discharged from the admitting hospital without receiving the necessary procedure or treatment and that the recipient be readmitted to a different hospital to obtain the necessary procedure or treatment. In this case, both hospitals shall retain their certification numbers subject to the hospitals' and admitting physicians' compliance with all requirements of parts 9505.0501 to 9505.0545, and medical assistance payment to each hospital must be made according to the transfer payment established under part 9500.1128, subpart 2, item D, for the inpatient hospital services necessary for the recipient's diagnosis and treatment.

B. The readmission results from a referral from one hospital to a different hospital because the recipient's medically necessary treatment was outside the scope of the first hospital's available inpatient hospital services. In this case, both hospitals shall retain their certification numbers, and medical assistance payment to each hospital must be made according to the transfer payment established under part 9500.1128, subpart 2, item D, for the inpatient hospital services necessary for the recipient's diagnosis and treatment. If, however, the admission to the first hospital is not due to an emergency and the first hospital knew or had reason to know at the time of admission that the inpatient hospital services that were medically necessary for the recipient's treatment or condition were outside the scope of the hospital's available inpatient hospital

services and the readmission to another hospital resulted because of the recipient's need for those services, the first hospital's certification number will be withdrawn.

C. The readmission results from a physician's or hospital's scheduling conflict at the admitting hospital. The medical review agent shall determine both hospitals eligible to retain their certification numbers. In this case, medical assistance payment to each hospital shall be made according to the transfer payment established under part 9500.1128, subpart 2, item D, for the inpatient hospital services necessary for the recipient's diagnosis and treatment.

Subp. 6. [Repealed, 23 SR 298]

Statutory Authority: *MS s 256.0625; 256.9353; 256.991; 256B.04; 256B.503; 256D.03*

History: *9 SR 2296; 11 SR 1687; 13 SR 1688; 18 SR 1115; 20 SR 2405; 23 SR 298*

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9505.0545 APPEALS.

Subpart 1. **Appeal by admitting physician or hospital.** The admitting physician or hospital may appeal the determination of the reconsideration under part 9505.0520, subparts 9, 9b, and 9c, according to Minnesota Statutes, section 256.9685, subdivisions 1b to 1d. The request for the appeal must be in writing and must be submitted to the commissioner within 30 days after receiving notice that the denial was upheld. An admitting physician or hospital that did not request a reconsideration under subpart 9 within 30 days of receiving the certified letter denying or withdrawing admission certification is not entitled to further appeal. The commissioner shall determine the medical necessity of the hospital admission based upon a review of the recipient's medical record and the information submitted by the provider during the reconsideration process and the medical review agent's basis for the determination that the services were not medically necessary for inpatient hospital services. The commissioner's decision under this subpart is the final agency decision.

Subp. 2. **Judicial review.** If the commissioner upholds the denial or withdrawal of admission certification, a hospital or admitting physician may appeal the commissioner's order to the district court of the county in which the hospital or physician is located. The appeal must be in writing and served upon the commissioner within 30 days after the date of the commissioner's order denying or withdrawing admission certification. The appeal must also be filed with the court administrator of the district court. The procedures to be followed by the court in processing the appeal are set out in Minnesota Statutes, section 256.9685, subdivisions 1c and 1d.

Subp. 3. **Appeal by recipient.** A recipient who is denied inpatient hospital services because of the medical review agent's determination that the inpatient hospital services are not medically necessary may appeal the medical review agent's determination according to Minnesota Statutes, section 256.045.

Statutory Authority: *MS s 256.9353; 256B.04; 256D.03*

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EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

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 disabling 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.04; 256B.0625*

History: *13 SR 1150; 16 SR 2518; L 2005 c 56 s 2*

Published Electronically: *August 12, 2008*

9505.1696 DEFINITIONS.

Subpart 1. **Applicability.** As used in parts 9505.1693 to 9505.1748, the following terms have the meanings given them.

Subp. 2. **Child.** "Child" means a person who is eligible for early and periodic screening, diagnosis, and treatment under part 9505.1699.

Subp. 3. **Community health clinic.** "Community health clinic" means a clinic that provides services by or under the supervision of a physician and that:

A. is incorporated as a nonprofit corporation under Minnesota Statutes, chapter 317A;

B. is exempt from federal income tax under Internal Revenue Code of 1986, section 501(c)(3), as amended through December 31, 1987;

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

D. has written clinic policies describing the services provided by the clinic and concerning (1) the medical management of health problems, including problems that require referral to physicians, (2) emergency health services, and (3) the maintenance and review of health records by the physician.

Subp. 4. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 5. **Diagnosis.** "Diagnosis" means the identification and determination of the nature or cause of a disease or abnormality through the use of a health history; physical, developmental, and psychological examination; and laboratory tests.

Subp. 6. **Early and periodic screening clinic or EPS clinic.** "Early and periodic screening clinic" or "EPS clinic" means an individual or facility that is approved by the Minnesota Department of Health under parts 4615.0900 to 4615.2000.

Subp. 7. **Early and periodic screening, diagnosis, and treatment program or EPSDT program.** "Early and periodic screening, diagnosis, and treatment program" or "EPSDT program" means the program that provides screening, diagnosis, and treatment under parts 9505.1693 to 9505.1748; Code of Federal Regulations, title 42, section 441.55, as amended through October 1, 1986; and Minnesota Statutes, section 256B.02, subdivision 8, paragraph (12).

Subp. 8. **EPSDT clinic.** "EPSDT clinic" means a facility supervised by a physician that provides screening according to parts 9505.1693 to 9505.1748 or an EPS clinic.

Subp. 9. **EPSDT provider agreement.** "EPSDT provider agreement" means the agreement required by part 9505.1703, subpart 2.

Subp. 10. [Repealed, L 2015 c 78 art 5 s 5]

Subp. 11. **Follow-up.** "Follow-up" means efforts by a local agency to ensure that a screening requested for a child is provided to that child and that diagnosis and treatment indicated as necessary by a screening are also provided to that child.

Subp. 12. **Head Start agency.** "Head Start agency" refers to the child development program administered by the United States Department of Health and Human Services, Office of Administration for Children, Youth and Families.

Subp. 13. **Local agency.** "Local agency" means the county welfare board, multicounty welfare board, or human service agency established in Minnesota Statutes, section 256B.02, subdivision 6, and Minnesota Statutes, chapter 393.

Subp. 14. **Medical assistance.** "Medical assistance" means the program authorized by title XIX of the Social Security Act and Minnesota Statutes, chapters 256 and 256B.

Subp. 15. **Outreach.** "Outreach" means efforts by the department or a local agency to inform eligible persons about early and periodic screening, diagnosis, and treatment or to encourage persons to use the EPSDT program.

Subp. 16. **Parent.** "Parent" refers to the genetic or adoptive parent of a child.

Subp. 17. **Physician.** "Physician" means a person who is licensed to provide health services within the scope of the person's profession under Minnesota Statutes, chapter 147.

Subp. 18. **Prepaid health plan.** "Prepaid health plan" means a health insurer licensed and operating under Minnesota Statutes, chapters 60A, 62A, and 62C, and a health maintenance organization licensed and operating under Minnesota Statutes, chapter 62D to provide health services to recipients of medical assistance entitlements.

Subp. 19. **Public health nursing service.** "Public health nursing service" means the nursing program provided by a community health board under Minnesota Statutes, section 145A.04, subdivisions 1 and 1a.

Subp. 20. **Screening.** "Screening" means the use of quick, simple procedures to separate apparently well children from those who need further examination for possible physical, developmental, or psychological problems.

Subp. 21. **Skilled professional medical personnel and supporting staff.** "Skilled professional medical personnel" and "supporting staff" means persons as defined by Code of Federal Regulations, title 42, section 432.2, as amended through October 1, 1987.

Subp. 22. **Treatment.** "Treatment" means the prevention, correction, or amelioration of a disease or abnormality identified by screening or diagnosis.

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

History: *13 SR 1150; L 1989 c 304 s 137; L 2015 c 21 art 1 s 109; L 2015 c 78 art 5 s 5*

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9505.1699 ELIGIBILITY TO BE SCREENED.

A person under age 21 who is eligible for medical assistance is eligible for the EPSDT program.

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

History: *13 SR 1150*

Published Electronically: *August 12, 2008*

9505.1701 CHOICE OF PROVIDER.

Subpart 1. **Choice of screening provider.** Except as provided by subpart 3, a child or parent of a child who requests screening may choose any screening provider who has signed an EPSDT provider agreement and a medical assistance provider agreement.

Subp. 2. **Choice of diagnosis and treatment provider.** Except as provided by subpart 3, a child or parent of a child may choose any diagnosis and treatment provider as provided by part 9505.0190.

Subp. 3. **Exception to subparts 1 and 2.** A child who is enrolled in a prepaid health plan must receive screening, diagnosis, and treatment from that plan.

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

History: *13 SR 1150*

Published Electronically: *August 12, 2008*

9505.1703 ELIGIBILITY TO PROVIDE SCREENING.

Subpart 1. **Providers.** An EPSDT clinic or a community health clinic shall be approved for medical assistance reimbursement for EPSDT services if it complies with the requirements of parts 9505.1693 to 9505.1748. A Head Start agency shall be approved as provided by subpart 2.

Subp. 2. **EPSDT provider agreement.** To be eligible to provide screening and receive reimbursement under the EPSDT program, an individual or facility must sign an EPSDT provider agreement provided by the department and a medical assistance provider agreement under part 9505.0195 or be a prepaid health plan.

Subp. 3. **Terms of EPSDT provider agreement.** The EPSDT provider agreement required by subpart 2 must state that the provider must:

A. screen children according to parts 9505.1693 to 9505.1748;

B. report all findings of the screenings on EPSDT screening forms; and

C. refer children for diagnosis and treatment if a referral is indicated by the screening.

The EPSDT provider agreement also must state that the department will provide training according to part 9505.1712 and will train and consult with the provider on billing and reporting procedures.

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

History: *13 SR 1150*

Published Electronically: *August 12, 2008*

9505.1706 REIMBURSEMENT.

Subpart 1. **Maximum payment rates.** Payment rates shall be as provided by part 9505.0445, item M.

Subp. 2. **Eligibility for reimbursement; Head Start agency.** A Head Start agency may complete all the screening components under part 9505.1718, subparts 2 to 14 or those components that have not been completed by another provider within the six months before completion of the screening components by the Head Start agency. A Head Start agency that completes the previously incomplete screening components must document on the EPSDT screening form that the other screening components of part 9505.1718, subparts 2 to 14, have been completed by another provider.

The department shall reimburse a Head Start agency for those screening components of part 9505.1718, subparts 2 to 14, that the Head Start agency has provided. The amount of reimbursement must be the same as a Head Start agency's usual and customary cost for each screening component or the maximum fee determined under subpart 1, whichever is lower.

Subp. 3. **Prepaid health plan.** A prepaid health plan is not eligible for a separate payment for screening. The early and periodic screening, diagnosis, and treatment screening must be a service included within the prepaid capitation rate specified in its contract with the department.

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

History: *13 SR 1150*

Published Electronically: *August 12, 2008*

9505.1709 [Repealed, L 2015 c 78 art 5 s 5]

Published Electronically: *August 31, 2015*

9505.1712 TRAINING.

The department must train the staff of an EPSDT clinic that is supervised by a physician on how to comply with the procedures required by part 9505.1718 if the EPSDT clinic requests the training.

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

History: *13 SR 1150*

Published Electronically: *August 12, 2008*

9505.1715 COMPLIANCE WITH SURVEILLANCE AND UTILIZATION REVIEW.

A screening provider must comply with the surveillance and utilization review requirements of parts 9505.2160 to 9505.2245.

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

History: *13 SR 1150*

Published Electronically: *August 12, 2008*

9505.1718 SCREENING STANDARDS FOR AN EPSDT CLINIC.

Subpart 1. **Requirement.** An early and periodic screening, diagnosis, and treatment screening must meet the requirements of subparts 2 to 15 except as provided by part 9505.1706, subpart 2.

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.

Subp. 3. **Assessment of physical growth.** The child's height or length and the child's weight must be measured and the results plotted on a growth grid based on data from the National Center for Health Statistics (NCHS). The head circumference of a child up to 36 months of age or a child whose growth in head circumference appears to deviate from the expected circumference for that child must be measured and plotted on an NCHS-based growth grid.

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

Subp. 5. **Vision.** A child must be checked for a family history of maternal and neonatal infection and ocular abnormalities. A child must be observed for pupillary reflex; the presence of nystagmus; and muscle balance, which includes an examination for esotropia, exotropia, phorias, and extraocular movements. The external parts of a child's eyes must be examined including the lids, conjunctiva, cornea, iris, and pupils. A child or parent of the child must be asked whether he or she has concerns about the child's vision.

Subp. 6. **Vision of a child age three or older.** In addition to the requirements of subpart 5, the visual acuity of a child age three years or older must be checked by use of the Screening Test for Young Children and Retardates (STYCAR) or the Snellen Alphabet Chart.

Subp. 7. **Hearing.** A child must be checked for a family history of hearing disability or loss, delay of language acquisition or history of such delay, the ability to determine the direction of a sound, and a history of repeated otitis media during early life. A child or parent of the child must be asked whether he or she has any concerns regarding the child's hearing.

Subp. 8. **Hearing of a child age three or older.** In addition to the requirements of subpart 7, a child age three or older must receive a pure tone audiometric test or referral for the test if the examination under subpart 7 indicates the test is needed.

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.

Subp. 10. **Sexual development.** A child must be evaluated to determine whether the child's sexual development is consistent with the child's chronological age. A female must receive a breast examination and pelvic examination when indicated. A male must receive a testicular examination when indicated. If it is in the best interest of a child, counseling on normal sexual development, information on birth control and sexually transmitted diseases, and prescriptions and tests must be offered to a child. If it is in the best interest of a child, a screening provider may refer the child to other resources for counseling or a pelvic examination.

Subp. 11. **Nutrition.** When the assessment of a child's physical growth performed according to subpart 3 indicates a nutritional risk condition, the child must be referred for further assessment, receive nutritional counseling, or be referred to a nutrition program such as the Special Supplemental Food Program for Women, Infants, and Children; food stamps or food support; Expanded Food and Nutrition Education Program; or Head Start.

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 Rev. Dr. Martin Luther King Jr. Blvd., 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.

A. A Mantoux test must be administered yearly to a child whose health history indicates ongoing exposure to tuberculosis, unless the child has previously tested positive. A child who tests positive must be referred for diagnosis and treatment.

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 minimum 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.

C. The urine of a child must be tested for the presence of glucose, ketones, protein, and other abnormalities. A female at or near the age of four and a female at or near the age of ten must be tested for bacteriuria.

D. Either a microhematocrit determination or a hemoglobin concentration test for anemia must be done.

E. A test for sickle cell or other hemoglobinopathy, or abnormal blood conditions must be offered to a child who is at risk of such abnormalities and who has not yet been tested. These tests must be provided if accepted or requested by the child or parent of the child. If the tests identify a hemoglobin abnormality or other abnormal blood condition, the child must be referred for genetic counseling.

F. Other laboratory tests such as those for cervical cancer, sexually transmitted diseases, pregnancy, and parasites must be performed when indicated by a child's medical or family history.

Subp. 14. **Oral examination.** An oral examination of a child's mouth must be performed to detect deterioration of hard tissue, and inflammation or swelling of soft tissue. Counseling about the systemic use of fluoride must be given to a child when fluoride is not available through the community water supply or school programs.

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.04; 256B.0625*

History: *13 SR 1150; 16 SR 2518; L 2003 1Sp14 art 1 s 106*

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9505.1724 PROVISION OF DIAGNOSIS AND TREATMENT.

Diagnosis and treatment identified as needed under part 9505.1718 shall be eligible for medical assistance payment subject to the provisions of parts 9505.0170 to 9505.0475.

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

History: *13 SR 1150*

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9505.1727 INFORMING.

A local agency must inform each child or parent of a child about the EPSDT program no later than 60 days after the date the child is determined to be eligible for medical assistance. The information about the EPSDT program must be given orally and in writing, indicate the purpose and benefits of the EPSDT program, indicate that the EPSDT program is without cost to the child or parent of the child while the child is eligible for medical assistance, state the types of medical and dental services available under the EPSDT program, and state that the transportation and appointment scheduling assistance required under part 9505.1730 is available.

The department must send a written notice to a child or parent of a child who has been screened informing the child or parent that the child should be screened again. This notice must be sent at the following ages of the child: six months, nine months, one year, 18 months, two years, four years, and every three years after age four.

Each year, on the date the child was determined eligible for medical assistance entitlements, the department must send a written notice to a child or parent of a child who has never been screened informing the child or parent that the child is eligible to be screened.

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

History: *13 SR 1150*

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9505.1730 ASSISTANCE WITH OBTAINING A SCREENING.

Within ten working days of receiving a request for screening from a child or parent of a child, a local agency must give or mail to the child or parent of the child:

A. a written list of EPSDT clinics in the area in which the child lives; and

B. a written offer of help in making a screening appointment and in transporting the child to the site of the screening.

If the child or parent of the child requests help, the local agency must provide it.

Transportation under this item must be provided according to part 9505.0140, subpart 1.

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

History: *13 SR 1150*

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9505.1733 ASSISTANCE WITH OBTAINING DIAGNOSIS AND TREATMENT.

An EPSDT clinic must notify a child or parent of a child who is referred for diagnosis and treatment that the local agency will provide names and addresses of diagnosis and treatment providers and will help with appointment scheduling and transportation to the diagnosis and treatment provider. The notice must be on a form provided by the department and must be given to the child or parent of the child on the day the child is screened.

If a child or parent of a child asks a local agency for assistance with obtaining diagnosis and treatment, the local agency must provide that assistance within ten working days of the date of the request.

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

History: *13 SR 1150*

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9505.1736 SPECIAL NOTIFICATION REQUIREMENT.

A local agency must effectively inform an individual who is blind or deaf, or who cannot read or understand the English language, about the EPSDT program.

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

History: *13 SR 1150*

Published Electronically: *August 12, 2008*

9505.1739 CHILDREN IN FOSTER CARE.

Subpart 1. **Dependent or neglected state wards.** The local agency must provide early and periodic screening, diagnosis, and treatment services for a child in foster care who is a dependent or neglected state ward under parts 9560.0410 to 9560.0470, and who is eligible for medical assistance unless the early and periodic screening, diagnosis, and treatment services are not in the best interest of the child.

Subp. 2. **Other children in foster care.** The local agency must discuss the EPSDT program with a parent of a child in foster care who is under the legal custody or protective supervision of the local agency or whose parent has entered into a voluntary placement agreement with the local agency. The local agency must help the parent decide whether to accept early and periodic screening, diagnosis, and treatment services for the child. If a parent cannot be consulted, the local agency must decide whether to accept early and periodic screening, diagnosis, and treatment services for the child and must document the reasons for the decision.

Subp. 3. **Assistance with appointment scheduling and transportation.** The local agency must help a child in foster care with appointment scheduling and transportation for screening, diagnosis, and treatment as provided by parts 9505.1730 to 9505.1733.

Subp. 4. **Notification.** The department must send a written notice to the local agency stating that a child in foster care who has been screened should be screened again. This notice must be sent at the following ages of the child: six months, nine months, one year, 18 months, two years, four years, and every three years thereafter.

Each year, by the anniversary of the date the child was determined eligible for medical assistance entitlements, the department must send a written notice to the local agency that a child in foster care who has never been screened is eligible to be screened.

If a written notice under this subpart pertains to a child who is a dependent or neglected state ward, the local agency must proceed according to subpart 1. The local agency must proceed according to subpart 2 if the written notice pertains to a child who is not a dependent or neglected state ward.

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

History: *13 SR 1150*

Published Electronically: *August 12, 2008*

9505.1742 DOCUMENTATION.

The local agency must document compliance with parts 9505.1693 to 9505.1748 on forms provided by the department.

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

History: *13 SR 1150*

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9505.1745 INTERAGENCY COORDINATION.

The local agency must coordinate the EPSDT program with other programs that provide health services to children as provided by Code of Federal Regulations, title 42, section 441.61(c), as amended through October 1, 1986. Examples of such agencies are a public health nursing service, a Head Start agency, and a school district.

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

History: *13 SR 1150*

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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 256E.31, subdivision 1, and "school district" means a school district as defined in Minnesota Statutes, section 120A.05, subdivisions 5, 10, and 14.

Subp. 2. **Federal financial participation.** The percent of federal financial participation for salaries, fringe benefits, and travel of skilled professional medical personnel and their supporting staff shall be paid as provided by Code of Federal Regulations, title 42, section 433.15(b)(5), as amended through October 1, 1986.

Subp. 3. **State reimbursement.** State reimbursement for contracts for EPSDT administrative services under this part shall be as provided by Minnesota Statutes, section 256B.19, subdivision 1, except for the provisions under subdivision 1 that pertain to a prepaid health plan.

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:

A. names of the contracting parties;

B. purpose of the contract;

C. beginning and ending dates of the contract;

D. amount of the contract, budget breakdown, and a clause that stipulates that the department's procedures for certifying expenditures will be followed by the local agency;

E. the method by which the contract may be amended or terminated;

F. a clause that stipulates that the contract will be renegotiated if federal or state program regulations or federal financial reimbursement regulations change;

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.04; 256B.0625*

History: *13 SR 1150; 16 SR 2518; L 1995 1Sp3 art 16 s 13; L 1998 c 397 art 11 s 3; L 2005 c 98 art 1 s 24*

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9505.1960 [Repealed, 15 SR 2563]

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9505.1980 [Repealed, 15 SR 2563]

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9505.1990 [Repealed, 15 SR 2563]

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9505.2000 [Repealed, 15 SR 2563]

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9505.2010 [Repealed, 15 SR 2563]

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9505.2150 [Repealed, 15 SR 2563]

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SURVEILLANCE AND INTEGRITY REVIEW PROGRAM

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, abuse, or error by vendors or recipients of health services through a program as defined in part 9505.2165, subpart 8, that is administered by the department, and for the imposition of sanctions against vendors and recipients of health services. Additionally, parts 9505.2160 to 9505.2245 establish standards applicable to the health service and financial records of vendors of health services through a program.

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, 152, 245, 245A, 252, 253, 254A, 254B, 256, 256B, 256D, 256L, and 609.

Subp. 2. **Applicability.** Parts 9505.2160 to 9505.2245 apply to local agencies, vendors participating in a program, and recipients of health services through a program. To the extent that provisions of a contract between the department and prepaid health plans have functionally equivalent requirements, the department shall exempt the prepaid health plans from the specific requirements of parts 9505.2160 to 9505.2245.

Statutory Authority: *MS s 256B.04; 256D.03*

History: *15 SR 2563, 19 SR 1898; L 2002 c 277 s 32; L 2003 1Sp14 art 11 s 11; 33 SR 127*

Published Electronically: *August 12, 2008*

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 vendor, a pattern of practices that are 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 vendor:

(1) submitting repeated claims, or causing claims to be submitted, from which required information is missing or incorrect;

(2) submitting repeated claims, or causing claims to be submitted, using procedure codes that overstate the level or amount of health service provided;

(3) submitting repeated claims, or causing claims to be submitted, for health services which are not reimbursable under the programs;

(4) submitting repeated duplicate claims, or causing claims to be submitted, for the same health service provided to the same recipient;

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

(6) submitting repeated claims, or causing claims to be submitted, for health 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 vendor's financial records as required by part 9505.2185;

(10) repeatedly failing to properly report duplicate payments from third party payers for covered health 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 false information to be submitted for the purpose of obtaining a service agreement, prior authorization, inpatient hospital admission certification under parts 9505.0501 to 9505.0540, or a second surgical opinion as required under part 9505.5035;

(14) 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 vendor has received reimbursement from or should have billed to the program;

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

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

(18) repeatedly failing to comply with the requirements of the provider agreement that relate to the programs covered by parts 9505.2160 to 9505.2245;

(19) failing to comply with the ownership and control information disclosure requirements of Code of Federal Regulations, title 42, part 455;

(20) billing for services that were provided to a recipient without the request or consent of the recipient, the recipient's guardian, or the recipient's responsible party;

(21) billing for services that were outside of the scope of the vendor's license, or in the case of a vendor that is not required to hold a license, billing by a vendor for services that the vendor is not authorized to provide under applicable regulatory agency requirements; or

(22) billing for services in a manner that circumvents the program's spenddown requirement;

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 or comparable services for the same health condition from a multiple number of vendors, such as going to multiple pharmacies or physicians. Duplicate or comparable services do 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 program 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 vendor;

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

(11) obtaining health services by false pretenses;

(12) repeatedly obtaining health services that are potentially harmful to the recipient;

(13) repeatedly obtaining emergency room health services for nonemergency care;

(14) repeatedly using medical transportation to obtain health services from providers located outside the local trade area when health services appropriate to the recipient's physical or mental health needs can be obtained inside the local trade area. For purposes of this subitem, "local trade area" has the meaning given in part 9505.0175, subpart 22; or

(15) repeatedly arranging for services and then canceling services in order to circumvent the spenddown requirement; and

C. in addition to the criteria in item B, the following practices are deemed to be abuse by a recipient enrolled in the restricted recipient program:

(1) obtaining medical services from a physician without a referral from the recipient's designated primary care provider;

(2) obtaining emergency room services for nonemergency care;

(3) obtaining prescriptions from a pharmacy other than the designated pharmacy; or

(4) obtaining health services from a nondesignated provider when the recipient has been required to designate a provider.

Subp. 2a. **Electronically stored data.** "Electronically stored data" means data stored by any electronic means, including, but not limited to, data stored in an existing or preexisting computer system or computer network, magnetic tape, or computer disk.

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:

A. acts which constitute a crime against any program, or attempts or conspiracies to commit those crimes, including the following:

(1) theft in violation of Minnesota Statutes, section 609.52;

(2) perjury in violation of Minnesota Statutes, section 609.48;

(3) aggravated forgery and forgery in violation of Minnesota Statutes, sections 609.625 and 609.63;

(4) medical assistance fraud in violation of Minnesota Statutes, section 609.466; and

(5) financial transaction card fraud in violation of Minnesota Statutes, section 609.821;

B. making a false statement, false claim, or false representation to a program where the person knows or should reasonably know the statement, claim, or representation is false, including knowingly and willfully submitting a false or fraudulent application for provider status; and

C. a felony listed in United States Code, title 42, section 1320a-7b(b)(3)(D), subject to any safe harbors established in Code of Federal Regulations, title 42, part 1001, section 952.

Subp. 4a. **Health plan.** "Health plan" means a health maintenance organization or other organization that contracts with the department to provide health services to recipients under a prepaid contract.

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 documentation of the health service that is electronically stored, written, or diagrammed that indicates the nature, extent, and evidence of the medical necessity of a health service provided by a vendor and billed to a program.

Subp. 6a. [Repealed, 19 SR 1898]

Subp. 6b. [Repealed, 19 SR 1898]

Subp. 6c. **Investigative costs.** "Investigative costs" are subject to the provisions of Minnesota Statutes, section 256B.064, subdivision 1d, and means the sum of the following expenses incurred by the department's investigator on a particular case:

A. hourly wage multiplied by the number of hours spent on the case;

B. employee benefits;

C. travel;

D. lodging;

E. meals; and

F. photocopying costs, paper, computer data storage or diskettes, and computer records and printouts.

Subp. 6d. **Lockout.** "Lockout" means excluding or limiting up to 24 months the scope of health services for which a vendor may receive payment through a program.

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

Subp. 6f. **Ownership or control interest.** "Ownership or control interest" has the meaning given in Code of Federal Regulations, title 42, part 455, sections 101 and 102.

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

Subp. 7. **Primary care provider.** "Primary care provider" means a provider designated by the department who is a physician or a group of physicians, nurse practitioner, or physician assistant practicing within the scope of the provider's practice, who is responsible for the direct care of a recipient, and for coordinating and controlling access to or initiating or supervising other health services needed by the recipient.

Subp. 8. **Program.** "Program" means the Minnesota medical assistance program, the general assistance medical care program, MinnesotaCare, consolidated chemical dependency program, prepaid health plans, home and community-based services under a waiver from the Centers for Medicare and Medicaid Services 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, and also includes a personal care provider.

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

Subp. 10a. **Responsible party.** "Responsible party" has the meaning given in Minnesota Statutes, section 256B.0655, subdivision 1h.

Subp. 10b. **Restricted recipient program.** "Restricted recipient program" means a program for recipients who have failed to comply with the requirements of the program. Placement in the restricted recipient program does not include long-term care facilities. Placement in the restricted recipient program means:

A. requiring the recipient for a period of 24 or 36 months of eligibility to obtain health services from a designated primary care provider, hospital, pharmacy, or other designated health service provider located in the recipient's local trade area; or

B. prohibiting the recipient from using the personal care assistant choice or consumer-directed services for a period of 24 months of eligibility.

Subp. 11. [Repealed, 33 SR 127]

Subp. 12. **Suspending participation or suspension.** "Suspending participation" or "suspension" means making a vendor ineligible for reimbursement through program funds 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 or termination.** "Terminating participation" or "termination" means making a vendor ineligible for reimbursement through program funds.

Subp. 15. **Theft.** "Theft" means the act defined in Minnesota Statutes, section 609.52, subdivision 2.

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

Subp. 16a. **Vendor.** "Vendor" has the meaning given to "vendor of medical care" in Minnesota Statutes, section 256B.02, subdivision 7. The term "vendor" includes a provider and also a personal care assistant. A vendor is subject to criminal background checks according to Minnesota Statutes, section 245C.03.

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; 256D.03*

History: *15 SR 2563; 16 SR 960; 19 SR 1898; L 2002 c 277 s 32; 33 SR 127; L 2011 1Sp11 art 3 s 12*

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9505.2175 HEALTH SERVICE RECORDS.

Subpart 1. **Documentation requirement.** As a condition for payment by a program, a vendor 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 9. Program funds paid for a health service not documented in a recipient's health service record shall be recovered by the department.

Subp. 2. **Required standards for health service records.** A vendor 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 vendor or 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 vendor'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 service plan as required by Minnesota Statutes, section 256B.092, or individual treatment plan. For purposes of this item, "plan of care" has the meaning given in part 9505.0175, subpart 35; and "individual treatment plan" has the meaning given in part 9505.0370, 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 vendor'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. **Medical transportation service records.** A medical transportation record must meet the requirements of subparts 1 and 2 and be signed by the driver and contain the following statement: "I certify and swear that I have accurately reported in this mileage log the miles I actually drove and the dates and times I actually drove them. I understand that misreporting the miles driven and hours worked is fraud for which I could face criminal prosecution or civil proceedings." Each transportation record for each trip must document:

A. the description and address of both the origin and destination, and the mileage for the most direct route from the origin to the destination;

B. the type of transportation provided;

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;

D. the name of the driver and license number of the vehicle used to transport the recipient;

E. whether the recipient is ambulatory or nonambulatory;

F. the time of the pick up and the time of the drop off with a.m. and p.m. designations;

G. the number of occupants in the vehicle; and

H. the name of the extra attendant when an extra attendant is used to provide special transportation services.

Subp. 5. **Durable medical equipment records.** A durable medical equipment record must meet the requirements of subparts 1 and 2 and must document:

A. the type of equipment, including the brand and model names, the model number, and serial number, if available;

B. whether the equipment is being rented or purchased by the recipient;

C. when equipment is sold to a recipient, whether the equipment is under warranty and the length of the warranty;

D. repairs made by the current durable medical equipment provider to the equipment;

E. a shipping invoice or a shipping invoice with a delivery service manifest showing the date of delivery that proves that the medical equipment was delivered to the recipient; and

F. a physician's order or licensed practitioner's order for the equipment that specifies the type of equipment and the expected length of time the equipment will be needed by the recipient.

Subp. 5a. **Medical supply record.** A medical supply record must meet the requirements of subparts 1 and 2 and must document:

A. a physician's order or licensed practitioner's order for the supplies that indicates the type of supply needed, the expected length of time the supplies will be needed, and the quantity needed;

B. the type and brand name of the supplies delivered to the recipient;

C. the quantity of each supply delivered to the recipient; and

D. a shipping invoice or a shipping invoice with a delivery service tracking log showing the date of delivery that proves the medical supply was delivered to the recipient.

Subp. 6. **Rehabilitative and therapeutic services records.** Rehabilitative and therapeutic service records must meet the requirements of subparts 1 and 2, must meet the criteria in part 9505.0412, and must document:

A. objective and measurable goals that relate to the recipient's functioning;

B. the need for the level of service;

C. the reason the skills of a professional physical therapist or occupational therapist are needed; and

D. a licensed practitioner's order for the rehabilitative and therapeutic services.

Subp. 7. **Personal care provider service records.** Health care service records maintained by a personal care provider, consumer-directed home care provider, or fiscal agent must meet the requirements of subparts 1 and 2 and must document:

A. a physician's initial order for personal care services in the form required by the commissioner, which shall be included prior to, or within 30 days after the start of such services, and documentation that the physician's order has been reviewed by the physician at least once every 365 days;

B. the care plan completed by the supervising qualified professional which details the qualified professional's instruction to the personal care assistant;

C. the department's notice of prior authorization which identifies the amount of personal care service and qualified professional supervision authorized for the recipient;

D. whether the recipient is in a shared care arrangement, and if so, the record must also meet the documentation requirements of Minnesota Statutes, section 256B.0655, subdivision 5, paragraph (g);

E. whether the recipient is using the flexible services use option authorized by Minnesota Statutes, section 256B.0655, subdivision 6;

F. whether the recipient is using a fiscal agent and if so, the name of the agent;

G. whether the recipient is using a consumer-directed service delivery alternative;

H. for all care arrangements, the following documentation must be made for each day that care is provided by each personal care assistant who provides care to the recipient:

(1) the recipient's name;

(2) the name of the personal care assistant providing services;

(3) the day, month, and year the personal care services were provided;

(4) the total number of hours spent providing personal care services to the recipient;

(5) the time of arrival at the site where personal care services were provided and the time of departure from the site where services were provided, including a.m. and p.m. designations;

(6) the personal care services provided;

(7) notes by the personal care assistant regarding changes in the recipient's condition, documentation of calls to the supervising qualified professional, and other notes as required by the supervising qualified professional;

(8) the personal care assistant's signature on the time sheets which record the hours worked by the personal care assistant, and must contain the following statement: "I certify and swear that I have accurately reported on this time sheet the hours I actually worked, the services I provided, and the dates and times worked. I understand that misreporting my hours is fraud for which I could face criminal prosecution and civil proceedings"; and

(9) the recipient's signature, stamp, or mark, or the responsible party's signature, if the recipient requires a responsible party;

I. in a shared care arrangement, the following additional requirements apply:

(1) each personal care assistant must satisfy the daily documentation requirements in item H and the documentation requirements of Minnesota Statutes, section 256B.0655, subdivision 5, paragraph (g), for each recipient;

(2) the qualified professional must document supervision of shared care services including:

(a) ongoing monitoring and evaluation of the effectiveness and appropriateness of shared care;

(b) the date, time of day, and number of hours spent supervising the provision of shared services;

(c) whether the supervision was face-to-face or another method of supervision;

(d) changes in the recipient's condition;

(e) scheduling issues; and

(f) recommendations;

(3) the qualified professional must document consent by the recipient or the recipient's responsible party, if any, for shared care; and

(4) the qualified professional must document revocation by the recipient or the recipient's responsible party, if any, of the shared care option;

J. authorization by the recipient's responsible party, if any, for personal care services provided outside the recipient's residence;

K. authorization by the responsible party, who is a parent of a minor recipient or a guardian of a recipient, which is approved and signed by the supervising nurse, to delegate to another adult the responsible party function for absences of at least 24 hours but not more than six days; and

L. supervision by the supervising qualified professional, including the date of the provision of supervision of personal care services as specified in part 9505.0335, subpart 4.

Subp. 8. **School-based service records.** A health service record for a child with an individualized education program who receives covered school-based services, special transportation, or assistive technology devices must meet the requirements of subparts 1 and 2 and must include the following information:

A. the medical diagnosis or condition that indicates the need for an individualized education program (IEP);

B. a current, complete copy of the recipient's IEP, individualized family service plan, or individual interagency intervention plan that documents the type, frequency, duration, and scope of the covered IEP services to be provided and measurable outcomes;

C. a copy of the recipient's release of information to bill a Minnesota health care program for IEP services signed by the recipient's parent or legal representative, or a copy of the notice provided by the district to the parent or legal representative under Minnesota Statutes, section 125A.21, subdivision 2, paragraph (b);

D. the name of the school district that provided the service and the recipient's date of birth;

E. for IEP assistive technology devices, a description of the device, including type of device, manufacturer, model, and quantity of devices, and a copy of the invoice or rental agreement; and

F. for IEP special transportation services:

(1) mileage for the most direct route from the place where the recipient is picked up and transported to the school setting where IEP covered services are provided to the recipient;

(2) type of service provided and service code;

(3) name, title, and signature of a person who can verify that the recipient received IEP special transportation on the dates specified; and

(4) documentation that the recipient received another MHCP-covered IEP service on the date for which the special transportation is billed.

Subp. 9. **Language interpreter services.** A language interpreter service record must meet the requirements of subparts 1 and 2 and must document:

A. the name of the interpreter;

B. the name of the company that employed the interpreter;

C. the relationship of the interpreter to the recipient;

D. the languages spoken by the recipient and a statement that the recipient has limited English language proficiency;

E. a statement that the billed interpreter services were provided directly to the recipient while the recipient received a medically necessary covered health service; and

F. the length of time in hours and minutes that the language interpreter spent with the recipient during the direct person-to-person covered health service.

Statutory Authority: *MS s 245.484; 256B.04; 256D.03*

History: *15 SR 2563; 19 SR 1898; 33 SR 127; 35 SR 1967; L 2011 1Sp11 art 3 s 12*

Published Electronically: *February 18, 2013*

9505.2180 FINANCIAL RECORDS.

Subpart 1. **Financial records required of vendors.** The financial records, including written and electronically stored data, of a vendor who receives payment for a recipient's services under a program must contain the material specified in items A to I:

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

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

C. evidence of the vendor'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 vendor's appointment books for patient appointments and the 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 vendor;

H. employee records for those persons currently employed by the vendor or who have been employed by the vendor at any time within the previous five years which under Minnesota Statutes, chapter 13, would be considered public data for a public employee such as employee name, salary, qualifications, position description, job title, and dates of employment; in addition employee records shall include the employee's time sheets, current home address of the employee or the last known address of any former employee, and criminal background checks, when required; and

I. delivery tracking information, where applicable, such as the provider's shipping invoice, delivery manifest, or the delivery service's tracking slip.

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; 256D.03*

History: *15 SR 2563; 19 SR 1898; 33 SR 127*

Published Electronically: *August 12, 2008*

9505.2185 ACCESS TO RECORDS.

Subpart 1. **Recipient's consent to access.** A recipient is deemed to have authorized in writing a vendor or others to release to the department for examination according to Minnesota Statutes, section 256B.27, subdivision 4, upon the department's request, the recipient's health service records related to services under a program. The recipient's authorization of the release and review of health service records for services provided while the person is a recipient shall be presumed competent if given in conjunction with the person's application for a program. 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 records.** A vendor shall grant the department access during the department's normal business hours to examine health service and financial records related to a health service billed to a program. A vendor shall make its records available at the vendor's place of business on the day for which access was requested, unless the vendor and the department both agree that the records will be viewed at another location. Access to a recipient's health service record or vendor's records shall be for the purposes in part 9505.2200, subpart 1. The department shall notify the vendor no less than 24 hours before obtaining access to a health service or financial record, unless the vendor waives notice. The department's normal business hours are 8:00 a.m. to 5:00 p.m. Monday through Friday, excluding state holidays as defined in Minnesota Statutes, section 645.44, subdivision 5.

Statutory Authority: *MS s 256B.04; 256D.03*

History: *15 SR 2563; 19 SR 1898; 33 SR 127*

Published Electronically: *August 12, 2008*

9505.2190 RETENTION OF RECORDS.

Subpart 1. **Retention required; general.** A vendor shall retain all health service and financial records 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 or electronically stored 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. Vendors must maintain and store records in a manner that will allow for review by the department within the times set forth in part 9505.2185, subpart 2.

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

Subp. 3. **Record retention under change of ownership.** If the ownership of a long-term care facility or vendor 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 vendor 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; 256D.03*

History: *15 SR 2563; 19 SR 1898; 33 SR 127*

Published Electronically: *August 12, 2008*

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 claim or payment is made under a program. Photocopying shall be done on the vendor's premises on the day of the audit unless removal is specifically permitted by the vendor. If requested, a vendor must help the department duplicate any health service record or financial record, including hard copy or electronically stored data on the day of the audit.

Statutory Authority: *MS s 256B.04; 256D.03*

History: *15 SR 2563; 19 SR 1898; 33 SR 127*

Published Electronically: *August 12, 2008*

9505.2197 VENDOR'S RESPONSIBILITY FOR ELECTRONIC RECORDS.

A vendor's use of electronic record keeping or electronic signatures shall meet the following requirements:

A. use of electronic record keeping or electronic signatures does not alter the vendor's obligations under state or federal law, regulation, or rule;

B. the vendor is responsible for all claims submitted by the vendor or the vendor's designee to the department regardless of the format in which the health service or financial record is maintained;

C. the vendor must ensure that the use of electronic record keeping does not limit the commissioner's access to records;

D. upon request, the vendor shall help department staff to access and copy all records, including encrypted records and electronic signatures; and

E. the vendor must establish a mechanism or procedure to ensure that:

(1) the act of creating the electronic record or signature is attributable to the vendor, according to Minnesota Statutes, section 325L.09;

(2) the electronic records and signatures are maintained in a form capable of being retained and accurately reproduced;

(3) the department has access to information that establishes the date and time that data and signatures were entered into the electronic record; and

(4) the vendor's use of electronic record keeping or electronic signatures does not compromise the security of the records.

Statutory Authority: *MS s 256B.04*

History: *33 SR 127*

Published Electronically: *August 12, 2008*

9505.2200 IDENTIFYING FRAUD, THEFT, ABUSE, OR ERROR.

Subpart 1. **Department investigation.** The department shall investigate vendors or recipients to monitor compliance with program requirements for the purposes of identifying fraud, theft, abuse, or error in 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 Minnesota Statutes, section 145.61, subdivision 5, or their representatives;

D. consultants under contract in part 9505.0185;

E. recipients and their responsible relatives;

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

G. professional associations of vendors 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, 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 vendor, the vendor's employees, and entities under contract with the vendor 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 vendor or the recipient is in compliance with the requirements of a program and program payments were properly made;

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

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

Subp. 5. **Postinvestigation actions.**

A. After completing the determination required under subpart 4, the department shall take one or more of the actions specified in subitems (1) to (8):

(1) close the investigation when no further action is warranted;

(2) impose administrative sanctions according to part 9505.2210;

(3) seek monetary recovery according to part 9505.2215;

(4) refer the investigation to the appropriate state regulatory agency, peer review mechanism, or licensing board;

(5) refer the investigation to the attorney general or, if appropriate, to a county attorney for possible civil or criminal legal action;

(6) issue a warning that states the practices are potentially in violation of program laws or regulations;

(7) refer the investigation to the appropriate child or adult protection agency; or

(8) place the recipient in the restricted recipient program.

B. After completing the determination required under subpart 4, the department may seek recovery of investigative costs from a vendor under Minnesota Statutes, section 256B.064, subdivision 1d.

Statutory Authority: *MS s 256B.04; 256D.03*

History: *15 SR 2563; 19 SR 1898; 33 SR 127*

Published Electronically: *August 12, 2008*

9505.2205 IMPOSITION OF VENDOR SANCTIONS.

The commissioner shall decide what sanction shall be imposed against a vendor under part 9505.2210. The commissioner shall consider the following factors in determining the sanctions to be imposed on a vendor:

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

B. history of fraud, theft, abuse, or error; and

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

Statutory Authority: *MS s 256B.04; 256D.03*

History: *15 SR 2563; 19 SR 1898; 33 SR 127*

Published Electronically: *August 12, 2008*

9505.2207 PLACEMENT OF RECIPIENT IN RESTRICTED RECIPIENT PROGRAM.

The commissioner shall decide based upon information gathered under part 9505.2200 whether to place a recipient in the restricted recipient program. The commissioner shall consider the recipient's access to the local trade area, access to medically necessary services, and personal preference in the choice of providers.

Statutory Authority: *MS s 256B.04*

History: *33 SR 127*

Published Electronically: *August 12, 2008*

9505.2210 ADMINISTRATIVE SANCTIONS FOR VENDORS.

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, abuse, or error in connection with a program or if the vendor 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 to C are administrative sanctions that the commissioner may impose for the conduct specified in subpart 1.

A. For any vendor, the actions are:

(1) suspending or terminating the vendor's participation;

(2) suspending or terminating the participation of any person or corporation with whom the vendor has any ownership or control interest;

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

(4) requiring prior authorization of services; and

(5) lockout of the vendor's participation in a program.

B. For a provider, the actions in item A, and in addition:

(1) requiring a provider agreement of limited duration;

(2) requiring a provider agreement which stipulates specific conditions of participation; and

(3) review of the provider's claims before payment.

Subp. 3. [Repealed, 33 SR 127]

Statutory Authority: *MS s 256B.04; 256D.03*

History: *15 SR 2563; 19 SR 1898; 33 SR 127*

Published Electronically: *August 12, 2008*

9505.2215 MONETARY RECOVERY.

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

A. from a vendor, if payment for a recipient's health service under a program was the result of fraud, theft, abuse, or error on the part of the vendor, 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, 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 program payments; 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 270C.40. Interest may accrue from the effective date of recovery, as specified in part 9505.2230, subpart 2.

Statutory Authority: *MS s 256B.04; 256D.03*

History: *15 SR 2563; 19 SR 1898; L 2005 c 151 art 1 s 116; 33 SR 127*

Published Electronically: *August 12, 2008*

9505.2220 MONETARY RECOVERY; RANDOM SAMPLE EXTRAPOLATION.

Subpart 1. **Authorization.** For the purpose of part 9505.2215, the commissioner is authorized to calculate the amount of monetary recovery from a vendor based upon extrapolation from a systematic random sample of claims submitted by the vendor 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 vendor in the appeal process, the department shall use the extrapolation as the monetary recovery figure specified in subpart 3.

Subp. 2. **Decision to use samples.** The department may use sampling and extrapolation to calculate a monetary recovery if:

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

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

Subp. 3. **Statistical method.** The department shall use the methods in items A to D in calculating the amount of monetary recovery by random sample extrapolation. The federal share of overpayment determined by the federal government under a federal random sample extrapolation method shall be recovered by the department from a medical assistance vendor according to Minnesota Statutes, section 256B.0641, subdivision 1, clause (1).

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, these samples are called simple random samples. The department may choose to employ other sampling designs, such as the stratified random sampling, if it determines that those designs are more likely to lead to greater precision, or a closer approximation to the population mean. The department shall tell the provider the sampling method the department is using prior to drawing the sample.

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

C. The sampling method, including drawing the sample, calculating values, and extrapolating from the results of the sample, shall be performed 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. Samples must consist of at least 50 claims. Each stratum in a stratified sample must contain at least 30 claims or, if a population stratum contains less than 30 claims, all of the claims in that population stratum.

D. The vendor shall be required to pay the department the estimated overpayment only if the null hypothesis that the mean overpayment is less than or equal to zero can be rejected with probability less than 0.05. The amount owed to the department shall be the mean overpayment multiplied by the number of claims in the population. With simple random samples, the mean overpayment is the sum of all differences between correct and actual charges in the sample, divided by the number of claims in the sample. With stratified samples, the mean overpayment is the sum of the products of the mean differences within strata and the proportion of all claims in the population that are in the strata.

Statutory Authority: *MS s 256B.04; 256D.03*

History: *15 SR 2563; 19 SR 1898; 33 SR 127*

Published Electronically: *August 12, 2008*

9505.2225 PROVIDER OR VENDOR SUSPENSION.

The commissioner shall suspend a vendor 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; 256D.03*

History: *15 SR 2563; 19 SR 1898*

Published Electronically: *August 12, 2008*

9505.2230 NOTICE OF AGENCY ACTION.

Subpart 1. **Required written notice.** The department shall give notice in writing to a vendor or recipient of a monetary recovery, placement in the restricted recipient program, or administrative sanction that is to be imposed by the department. For vendors, the notice shall be sent by certified mail. For recipients, the notice shall be sent by first class mail. The department shall place an affidavit of the first class mailing in the recipient's file as an indication of the date of mailing and the address.

A. In all cases, the notice shall state:

(1) the factual basis for the department's determination according to part 9505.2200, subpart 4;

(2) the actions the department plans to take;

(3) the dollar amount of the monetary recovery, if any;

(4) how the dollar amount was computed;

(5) the right to dispute the department's determinations and to provide evidence; and

(6) the right to appeal the department's proposed action under part 9505.2245.

B. In cases of vendor suspension or termination under part 9505.2235, in addition to the requirements of item A, the notice shall state:

(1) the length of the suspension or termination;

(2) the effect of the suspension or termination;

(3) the earliest date on which the department shall consider a request for reinstatement;

(4) the requirements and procedures for reinstatement; and

(5) the vendor's right to submit documents and written argument against the suspension for review by the commissioner before the effective date of suspension or termination.

The submission of documents and written argument for review by the commissioner under subitem (5) does not stay the deadline for filing a formal appeal under part 9505.2245.

Subp. 2. **Effective date of recovery or sanction.** For vendors, 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; 256D.03*

History: *15 SR 2563; 19 SR 1898; 33 SR 127*

Published Electronically: *August 12, 2008*

9505.2231 SUSPENSION OR WITHHOLDING OF PAYMENTS.

Subpart 1. **Grounds for suspension or withholding before an appeal.** 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*

Published Electronically: *August 12, 2008*

9505.2235 SUSPENSION OR TERMINATION OF VENDOR PARTICIPATION.

Subpart 1. **Effect of suspension or termination.** 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 professional association except in the case of claims for payment for health services provided before the 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.** A vendor who is under suspension or terminated from participation is eligible to apply for reinstatement as a provider or vendor 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 participation requirements of part 9505.0195 and Code of Federal Regulations, title 42, section 1002.215.

Subp. 3. **Prohibited submission of vendor's claims.** A provider 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 provider 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 provider if the commissioner determines that the provider knew or had reason to know of the suspension or termination.

Statutory Authority: *MS s 256B.04; 256D.03*

History: *15 SR 2563; 19 SR 1898*

Published Electronically: *August 12, 2008*

9505.2236 RESTRICTION OF PROVIDER OR VENDOR PARTICIPATION.

Subpart 1. **Effect of restriction on a provider or vendor.** The provider agreement of a vendor 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. A vendor 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 vendor, either directly or indirectly, for restricted services or charges specified in the notice of action.

Subp. 2. **Reinstatement of restricted provider or vendor.** A vendor who is restricted from participation is eligible to apply for reinstatement as an unrestricted provider or vendor at the end of the period of restriction. The department shall review a vendor's application to determine whether the vendor is qualified to participate without restrictions as specified by the participation requirements of part 9505.0195 and Code of Federal Regulations, title 42, section 1002.215.

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

Statutory Authority: *MS s 256B.04; 256D.03*

History: *15 SR 2563; 19 SR 1898*

Published Electronically: *August 12, 2008*

9505.2238 PLACEMENT IN RESTRICTED RECIPIENT PROGRAM.

Subpart 1. **Effect of placement.** A recipient who has been placed in the restricted recipient program is eligible to receive health care services only from the designated providers. A recipient is placed in the restricted recipient program for a period of 24 months of eligibility. The period of 24 months of eligibility begins at the time of placement in the restricted recipient program. A recipient will be given 30 days to designate specific providers. At the end of the 30 days, the department shall designate specific providers for a recipient who has failed to designate specific providers. A recipient who has been prohibited from using the personal care assistant choice or consumer-directed services option shall be prohibited from using that option for a period of 24 months of eligibility.

Subp. 2. **Change in selected providers.** A recipient may change designated providers under the following circumstances:

A. a recipient may change designated providers for any stated reason after the initial three months of restriction, provided the changes do not occur more than twice in one year; and

B. a recipient may change designated providers as often as needed under the circumstances in subitems (1) to (3):

(1) if the recipient moves outside of the designated provider's local trade area;

(2) if the recipient is discharged by the designated provider; or

(3) other circumstances that require the recipient to change designated providers.

The department shall grant the recipient's request to change designated providers under this subpart if the change is consistent with protecting the integrity of the restricted recipient program.

Subp. 3. **Placement renewal.** After a recipient has completed an initial 24-month period of eligibility in the restricted recipient program, the department may renew the recipient's placement in the restricted recipient program under part 9505.2165, subpart 2, item C, by sending written notice to the recipient. The recipient will remain placed in the restricted recipient program pending the resolution of an appeal of the placement renewal. If the recipient's placement is not renewed, the recipient shall be notified by the department that the recipient's participation in the restricted recipient program is over. Renewal of the recipient's placement in the restricted recipient program shall be for an additional period of 36 months of eligibility.

Subp. 4. **Emergency health services.** Emergency health services provided to a recipient in the restricted recipient program by a vendor shall be eligible for payment if the service provided meets the definition of an emergency in part 9505.0175, subpart 11. The vendor must provide documentation of the emergency circumstances with the emergency service payment claim.

Statutory Authority: *MS s 256B.04*

History: *33 SR 127*

Published Electronically: *August 12, 2008*

9505.2240 NOTICE TO THIRD PARTIES.

Subpart 1. **Notice about vendors.** After the department has taken an action against a vendor as specified in part 9505.2210, subpart 2, item A or B, 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 to C.

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 (1), (2), (4), or (5), by publishing the notice in a general circulation newspaper in the geographic area of Minnesota generally served by the vendor in the majority of its health services to Minnesota program recipients. The notice shall include the vendor's name and service type, the action taken by the department, and the effective date or dates of the action.

C. If the vendor requests reinstatement and the department approves the request for reinstatement, the department shall give written notice to the vendor and those notified in items A and B about the action taken under part 9505.2210, subpart 2, item A, subitem (1), (2), (4), or (5), and the reinstatement.

Subp. 2. **Information and notice about recipients.** After the department has placed the recipient in the restricted recipient program as specified in parts 9505.2207 and 9505.2238 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 provider and other health care providers that the recipient has been placed in the restricted recipient program and the circumstances leading to the placement. Notice shall include the recipient's name, program, the nature of the placement of the recipient in the restricted recipient program, a list of providers from whom the recipient may receive medical services, and the beginning and ending dates of the placement period. The recipient's placement in the restricted recipient program must be indicated in an eligibility verification system.

Statutory Authority: *MS s 256B.04; 256D.03*

History: *15 SR 2563; 19 SR 1898; 33 SR 127*

Published Electronically: *August 12, 2008*

9505.2245 APPEAL OF DEPARTMENT ACTION.

Subpart 1. **Vendor's right to appeal.** A vendor may appeal the department's proposed actions under parts 9505.2210, 9505.2215, and 9505.2220, under the provisions of Minnesota Statutes, sections 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 vendor believes is correct;

(3) the authority in the statute or rule upon which the vendor 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.

C. Before the appeal hearing, the commissioner may suspend or reduce payment to the provider, except a nursing facility or convalescent care facility, if the commissioner determines that action is necessary to protect the public welfare and the interests of the program.

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; 256D.03*

History: *15 SR 2563; 19 SR 1898; 33 SR 127*

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CONDITIONS FOR MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE PAYMENT

9505.5000 APPLICABILITY.

Parts 9505.5000 to 9505.5105 establish the procedures for prior authorization of health services and the requirement of a second surgical opinion as conditions of payment to providers of health services for recipients of medical assistance, MinnesotaCare, and general assistance medical care.

These parts shall be read in conjunction with title XIX of the Social Security Act, Code of Federal Regulations, title 42, sections 430.00 to 489.57; Minnesota Statutes, sections 256L.03; 256B.01 to 256B.40; 256B.64 to 256B.71; 256D.01 to 256D.21; parts 9505.0170 to 9505.0475; 9505.0501 to 9505.0545; 9505.1000 to 9505.1040; and 9505.2160 to 9505.2245, and with rules adopted by the commissioner under Minnesota Statutes, sections 256L.02, 256.991, and 256D.03, subdivision 7, paragraph (b).

Statutory Authority: *MS s 256.9352; 256.991; 256B.04; 256D.03; 256L.02*

History: *10 SR 842; 13 SR 1688; 19 SR 2433*

Published Electronically: *January 14, 2010*

9505.5005 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9505.5000 to 9505.5105 have the meanings given them in this part.

Subp. 1a. **Authorization number.** "Authorization number" means the number issued by:

A. the department, or an entity under contract to the department, to issue a number to a provider for the provision of a covered health service, as specified in part 9505.5010; or

B. the medical review agent that establishes that the surgical procedure requiring a second surgical opinion is medically appropriate.

Subp. 1b. **Certification number.** "Certification number" means the number issued by the medical review agent that establishes that all or part of a recipient's inpatient hospital services are medically necessary.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or an authorized designee.

Subp. 3. **Consultant.** "Consultant" means an individual who is licensed or registered according to state law or meets the credentials established by the respective professional organization in an area of health care or medical service; is employed by or under contract with the Department of Human Services; advises the department whether to approve, deny, or modify criteria for the approval of authorization requests in his or her area of expertise; advises the department on and recommends to the department policies concerning health services and whether health services meet the criteria in part 9505.5045; and performs other duties as assigned.

Subp. 4. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 5. **Emergency.** "Emergency" means a medical condition that, if not immediately diagnosed and treated, could cause a recipient serious physical or mental disability, continuation of severe pain, or death.

Subp. 6. **Fair hearing.** "Fair hearing" means an administrative proceeding under Minnesota Statutes, section 256.045 and as provided in part 9505.5105, to examine facts concerning the matter in dispute and to advise the commissioner whether the department's decision to reduce or deny benefits was correct.

Subp. 7. **General assistance medical care or GAMC.** "General assistance medical care" or "GAMC" means the health services provided to a recipient under the general assistance medical care program according to Minnesota Statutes, chapter 256D.

Subp. 8. **Health services.** "Health services" means the services and supplies furnished to a recipient by a provider as defined in subpart 16.

Subp. 9. **Investigative.** "Investigative" means:

A. A health service procedure which has progressed to limited human application and trial, which lacks wide recognition as a proven and effective procedure in clinical medicine as determined by the National Blue Cross and Blue Shield Association Medical Advisory Committee, and utilized by Blue Cross and Blue Shield of Minnesota in the administration of their program.

B. A drug or device that the United States Food and Drug Administration has not yet declared safe and effective for the use prescribed. For purposes of this definition, drugs and devices shall be those identified in the Food and Drug Act.

Subp. 10. **Local agency.** "Local agency" means a county or a multicounty agency that is authorized under Minnesota Statutes as the agency responsible for the administration of the medical assistance and general assistance medical care programs.

Subp. 11. **Local trade area.** "Local trade area" means the geographic area surrounding the recipient's residence which is commonly used by other persons in the same area to obtain necessary goods and services.

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 9505.5105.

Subp. 13. **Medicare.** "Medicare" means the health insurance program for the aged and disabled established by title XVIII of the Social Security Act.

Subp. 13a. **MinnesotaCare.** "MinnesotaCare" means the program established under Minnesota Statutes, sections 256L.01 to 256L.10.

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.

Subp. 15. **Prior authorization.** "Prior authorization" means the written approval and issuance of an authorization number by the department, or by an entity under contract to the department, to a provider for the provision of a covered health service, as specified in part 9505.5010, prior to payment for that service.

Subp. 16. **Provider.** "Provider" means an individual or organization under an agreement with the department to furnish health services to persons eligible for the medical assistance, general assistance medical care, or MinnesotaCare programs.

Subp. 17. **Recipient.** "Recipient" means a person who is eligible for and receiving benefits from the medical assistance, general assistance medical care, or MinnesotaCare programs.

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.

Subp. 18. **Referee.** "Referee" means an individual who conducts fair hearings under Minnesota Statutes, section 256.045 and recommends orders to the commissioner.

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]

Subp. 19. **Working days.** "Working days" means Monday through Friday, excluding state recognized legal holidays.

Statutory Authority: *MS s 256.0625; 256.9352; 256.991; 256B.04; 256D.03; 256L.02*

History: *10 SR 842; 13 SR 1688; 19 SR 2433; 20 SR 2405*

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9505.5010 PRIOR AUTHORIZATION REQUIREMENT.

Subpart 1. **Provider requirements.** A provider shall obtain prior authorization as a condition of payment under the medical assistance, general assistance medical care, and MinnesotaCare programs for health services designated under parts 9505.0170 to 9505.0475 and 9505.5025; and Minnesota Statutes, section 256B.0625, subdivision 25. The provider of the health service shall submit the request on form DHS-3065 or DHS-3066, or the American Dental Association (ADA) form as required in subpart 3, and shall submit materials, reports, progress notes, admission histories, and other information that substantiates that the service is medically necessary to treat the recipient. If the provider obtains prior authorization before the health service is provided but before payment, the provider shall be assured payment at the authorized level after the recipient has received the service. If a provider requests prior authorization after the service has been provided but before payment, the provider shall be assured of payment only if prior authorization is given. Additionally, prior authorization shall assure the provider payment 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, general assistance medical care, or MinnesotaCare programs.

Subp. 2. [Repealed, 19 SR 2433]

Subp. 3. **Submission of forms.** The provider shall submit to the department a request for prior authorization on form DHS-3065 or DHS-3066, or the American Dental Association (ADA) form, which has been completed according to instructions in the Minnesota Health Care Programs Provider Manual, and other information necessary to address the criteria in part 9505.5030. The provider shall bear the burden of establishing compliance with the criteria in part 9505.5030 and shall submit information which demonstrates that the criteria in part 9505.5030 are met. The provider who administers or supervises the recipient's care shall personally review and sign the form and any attached documentation.

Subp. 4. **Consequences for failure to obtain prior authorization.** A provider who furnishes health services without obtaining prior authorization under parts 9505.5010 to 9505.5030 shall be denied payment. A physician, hospital, or other provider who is denied payment because of failure to comply with parts

9505.5010 to 9505.5030 shall not seek payment from the recipient and the recipient shall not be liable for payment of the service for which the provider is denied payment due to lack of prior authorization.

Statutory Authority: *MS s 256.9352; 256.991; 256B.04; 256D.03; 256L.02*

History: *10 SR 842; 13 SR 1688; 16 SR 2102; 19 SR 2433*

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9505.5020 DEPARTMENT RESPONSIBILITIES.

Subpart 1. **Notification requirements.** If the information submitted by the provider does not meet the requirements of part 9505.5030, the department shall notify the provider of what is necessary to complete the request. The department shall send the provider, within 30 working days of receipt of all the information required in part 9505.5010, a notice of the action taken on the request for prior authorization. If the prior authorization request is denied, the department shall send the recipient within the same time period a copy of the notice sent to the provider and a statement of the recipient's right to appeal as provided in Minnesota Statutes, section 256.045.

Subp. 2. **Retention of information submitted by provider.** The department shall have the right to retain information submitted to the department by the provider in accordance with part 9505.5010.

Statutory Authority: *MS s 256.9352; 256.991; 256B.04; 256D.03; 256L.02*

History: *10 SR 842; 19 SR 2433*

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9505.5025 PRIOR AUTHORIZATION REQUIREMENT FOR HEALTH SERVICES PROVIDED OUTSIDE OF MINNESOTA.

Prior authorization for health services to be provided outside of Minnesota under part 9505.0215 must be obtained before the service is provided when, at the time of service, the recipient is located outside of Minnesota and the recipient's local trade area. A health service that is provided to a Minnesota resident outside of Minnesota but within the recipient's local trade area and that would not require prior authorization if it were provided to a Minnesota resident within Minnesota shall be exempt from the prior authorization requirement.

Statutory Authority: *MS s 256.9352; 256.991; 256B.04; 256D.03; 256L.02*

History: *10 SR 842; 19 SR 2433; 36 SR 10*

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9505.5030 CRITERIA FOR APPROVAL OF PRIOR AUTHORIZATION REQUEST.

A request for prior authorization of a health service shall be evaluated by consultants using the criteria given in items A to F. A health service meeting the criteria in this part shall be approved, if the health service is otherwise a covered service under the MA or GAMC programs. The health service must:

A. be medically necessary as determined by prevailing medical community standards or customary practice and usage;

B. be appropriate and effective to the medical needs of the recipient;

C. be timely, considering the nature and present state of the recipient's medical condition;

D. be furnished by a provider with appropriate credentials;

E. be the least expensive appropriate alternative health service available; and

F. represent an effective and appropriate use of program funds.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

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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: *10 SR 842; L 1988 c 689 art 2 s 268; 13 SR 1688; 20 SR 2405*

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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*

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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.

A. Authoritative medical literature identifies the surgical procedure as being overutilized.

B. The surgical procedure is shown to be utilized to a greater degree within the Medicaid population than in the non-Medicaid population.

C. The utilization or cost of a surgical procedure falls within the top ten percent of all surgical procedures reimbursed under the MA and GAMC programs.

D. Alternative methods of treatment which are less intrusive are available.

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

History: *10 SR 84; 20 SR 2405*

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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*

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9505.5075 PHYSICIAN RESPONSIBILITY.

When a surgical procedure is subject to a second medical opinion, 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: *10 SR 842; 13 SR 1688; 20 SR 2405*

Published Electronically: *August 12, 2008*

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 9505.5105, 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 nursing 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*

Published Electronically: *January 14, 2010*

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*

Published Electronically: *August 12, 2008*

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*

Published Electronically: *August 12, 2008*

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*

Published Electronically: *August 12, 2008*

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

Published Electronically: *August 12, 2008*

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*

Published Electronically: *August 12, 2008*

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: *10 SR 842; 20 SR 2405*

Published Electronically: *August 12, 2008*

9505.5090 [Repealed, 20 SR 2405]

Published Electronically: *August 12, 2008*

9505.5091 PENALTIES.

The penalties for failure to comply with parts 9505.5000 to 9505.5105 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*

Published Electronically: *January 14, 2010*

9505.5095 [Repealed, 13 SR 1688]

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9505.5096 [Repealed, 20 SR 2405]

Published Electronically: *August 12, 2008*

9505.5100 [Repealed, 20 SR 2405]

Published Electronically: *August 12, 2008*

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 opinion 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

B. no later than 90 days from the date notice of denial was received if the appeals referee finds there was good cause for the delay.

Subp. 4. **Fair hearing.** A referee shall conduct the hearing according to Minnesota Statutes, section 256.045, subdivision 4.

Subp. 5. **Commissioner's ruling.** Within 90 days of the date of receipt of the recipient's request for a hearing, the commissioner shall make a ruling to uphold, reverse, or modify the action or decision of the department or the medical review agent. The commissioner's ruling shall be binding upon the department and the recipient unless a request for judicial review is filed pursuant to Minnesota Statutes, section 256.045, subdivision 7.

Statutory Authority: *MS s 256.0625; 256.9352; 256.991; 256B.04; 256D.03; 256L.02*

History: *10 SR 842; L 1988 c 689 art 2 s 268; 13 SR 1688; 19 SR 2433; 20 SR 2405*

Published Electronically: *August 12, 2008*

DEPARTMENT HEALTH CARE PROGRAM PARTICIPATION REQUIREMENTS FOR VENDORS

AND HEALTH MAINTENANCE ORGANIZATIONS

9505.5200 PURPOSE.

Parts 9505.5200 to 9505.5240 establish requirements for participation by vendors and health maintenance organizations in the medical assistance program, general assistance medical care program, and MinnesotaCare as a condition of participating in other state health care programs.

Statutory Authority: *MS s 256B.0644*

History: *18 SR 2651*

Published Electronically: *August 12, 2008*

9505.5210 DEFINITIONS.

Subpart 1. **Applicability.** For the purposes of parts 9505.5200 to 9505.5240, the terms in this part have the meanings given them.

Subp. 2. **Capitation rate.** "Capitation rate" means a method of payment for health care services under which a monthly per person rate is paid on a prospective basis to a health plan.

Subp. 3. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designated representative.

Subp. 4. **Department.** "Department" means the Department of Human Services.

Subp. 5. **Department health care programs.** "Department health care programs" means:

A. general assistance medical care;

B. medical assistance; and

C. MinnesotaCare.

Subp. 6. **Fee-for-service.** "Fee-for-service" means a method of payment for health services under which a specific amount is paid for each type of health service provided a recipient.

Subp. 7. **General assistance medical care.** "General assistance medical care" has the meaning given in Minnesota Statutes, section 256D.02, subdivision 4a.

Subp. 8. **Geographic area.** "Geographic area" means a portion of a county, a county, or multiple counties as designated by the commissioner for purposes of providing department health care programs through a prepaid contract.

Subp. 9. **Health maintenance organization or HMO.** "Health maintenance organization" or "HMO" means an organization specified in Minnesota Statutes, section 62D.02, subdivision 4.

Subp. 10. **Health plan.** "Health plan" means a health maintenance organization or other organization that contracts with the department to provide health services to recipients under a prepaid contract.

Subp. 11. **Health services.** "Health services" means the goods and services eligible for payment under a department health care program.

Subp. 12. **Medical assistance.** "Medical assistance" means the program authorized under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 13. **MinnesotaCare.** "MinnesotaCare" means the program authorized under Minnesota Statutes, sections 256L.01 to 256L.12.

Subp. 14. **Other state health care programs.** "Other state health care programs" means:

A. health insurance plans for state employees covered under Minnesota Statutes, section 43A.18;

B. the workers' compensation system established under Minnesota Statutes, section 176.135;

C. the public employees insurance program authorized under Minnesota Statutes, section 43A.316;

D. insurance plans provided through the Minnesota comprehensive health association under Minnesota Statutes, sections 62E.01 to 62E.16; and

E. health insurance plans offered to local statutory or home rule charter city, county, and school district employees.

Subp. 15. **Prepaid contract.** "Prepaid contract" means a contract between the department and a health plan under which health services are provided recipients for a capitation rate.

Subp. 16. **Provider.** "Provider" means a vendor other than a health maintenance organization that has signed an agreement approved by the department for the provision of health services to a recipient.

Subp. 17. **Recipient.** "Recipient" means a person who is determined by the state or local agency to be eligible to receive health services under a department health care program.

Subp. 18. **Vendor.** "Vendor" means a vendor of medical care, other than a health maintenance organization, as defined in Minnesota Statutes, section 256B.02, subdivision 7.

Statutory Authority: *MS s 256B.0644*

History: *18 SR 2651*

Published Electronically: *August 12, 2008*

9505.5220 CONDITIONS OF PARTICIPATION; VENDOR OTHER THAN HEALTH MAINTENANCE ORGANIZATION.

Subpart 1. **Required participation.** As a condition of participating in the other state health care programs listed in part 9505.5210, subpart 14, a vendor other than a health maintenance organization must:

A. participate as a provider in the department health care programs; and

B. except as provided in subparts 3 and 4, accept on a continuous basis new patients who are recipients, and use the same acceptance criteria applied to new patients who are not recipients.

Subp. 2. **Exclusion from other state health care programs.** A vendor that fails to comply with the requirements of this part is excluded from participating in other state health care programs listed in part 9505.5210, subpart 14, except as provided in items A to C.

A. In geographic areas where provider participation in department health care programs is limited by department managed care contracts, a vendor that fails to comply is not excluded from participating in insurance plans offered to local government employees.

B. A vendor who enrolls as a provider at the request of the department for the sole purpose of ensuring continuity of care for recipients who are temporarily ineligible for the vendor's health plan is not

subject to the requirements of this part unless the vendor provides health services on a fee for service basis to patients not covered by department health care programs.

C. An independently owned physical therapy agency or occupational therapy agency, other than a Medicare-certified rehabilitation agency is not subject to the requirements of this part if:

(1) the agency is owned by at least one physical therapist or occupational therapist who is individually Medicare-certified and enrolled as a provider in the department health care programs;

(2) the agency accepts recipients on a continuous basis; and

(3) all health services provided recipients are provided by a therapist who is individually Medicare-certified.

This item does not require an agency to provide services to recipients that the agency does not provide other clients.

Subp. 3. **Limiting acceptance of recipients; 20 percent threshold.** A provider may limit acceptance of new patients who are recipients, only as provided in items A to D.

A. The provider, at least annually, shall determine annual active patient caseload. Annual active patient caseload means:

(1) the total number of patient encounters that result in a billing during the provider's most recent fiscal year; or

(2) if enrolled as a provider for less than a year, the total number of patient encounters that result in a billing during the period between enrollment and the end of the provider's fiscal year.

B. A provider may include, in the determination, patient encounters from all service sites enrolled under the provider's number but shall count only one patient encounter per patient per day regardless of the number of service sites involved in the patient's health care. A provider may count recipients receiving health services on a fee-for-service basis and under a prepaid contract.

C. If at least 20 percent of the provider's annual active patient case load are and continue to be recipients, the provider may refuse to accept new patients who are recipients for the remainder of the provider's fiscal year.

D. The provider shall notify the department in writing at least ten days before limiting acceptance of new patients who are recipients. The notice must include the active patient caseload data upon which the provider relied in calculating the percentage of patients who are recipients. The provider shall provide any other information required by the commissioner to verify compliance with parts 9505.5200 to 9505.5240.

Subp. 4. **Waiver.** A vendor may request a waiver from the participation requirements of this part in writing from the commissioner. The commissioner shall grant a waiver for up to one year and shall include the vendor on the list of participating providers in part 9505.5240 if:

A. the vendor is a provider who is not accepting new patients, regardless of payer source; or

B. the vendor is ineligible to enroll as a provider in the department health care programs because the vendor does not provide a covered health service.

Statutory Authority: *MS s 256B.0644*

History: *18 SR 2651*

Published Electronically: *August 12, 2008*

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

Published Electronically: *August 12, 2008*

9505.5240 REPORTS; EXCLUSION FROM PARTICIPATION.

Subpart 1. **Quarterly reports to state agencies.** The commissioner shall submit quarterly reports to the commissioners of management and budget, labor and industry, and commerce identifying the providers and health maintenance organizations in compliance with parts 9505.5200 to 9505.5240. The commissioner shall submit a master report of participating providers and HMOs on April 1 of each year and shall submit subsequent quarterly amendments. The commissioner shall publish in the State Register notice of the availability of the reports. The reports must be in a format mutually agreeable to the affected agencies.

Subp. 2. **Notice of noncompliance.** If the commissioner has reason to believe a participating provider or health maintenance organization is not in compliance with parts 9505.5200 to 9505.5240, the commissioner shall notify the provider or HMO in writing of the alleged noncompliance. The notice must state that the commissioners listed in subpart 1 will be notified and the provider or health maintenance organization will be excluded from participating in the other state health care programs listed in part 9505.5210, subpart 14, unless evidence of compliance is provided within 30 days.

Subp. 3. **Exclusion for noncompliance.** The commissioner shall consider evidence provided in response to a notice of alleged noncompliance. Within 30 days after receiving evidence provided, the commissioner shall notify the provider or health maintenance organization whether compliance has been demonstrated. If no evidence was submitted within 30 days of the notice under subpart 2, or the commissioner determines the provider or HMO is not in compliance, the commissioner shall remove the provider or HMO from the list of participating providers and HMOs in the next subsequent quarterly report.

Subp. 4. **Reinstatement.** The commissioner shall reinstate on the list of participating providers and health maintenance organizations in the quarterly report under subpart 1 an excluded provider or HMO that demonstrates compliance with parts 9505.5200 to 9505.5240.

Statutory Authority: *MS s 256B.0644*

History: *18 SR 2651; L 2008 c 204 s 42; L 2009 c 101 art 2 s 109*

Published Electronically: *January 14, 2010*

FAMILY PLANNING PROGRAM

9505.5300 APPLICABILITY.

Parts 9505.5300 to 9505.5325 govern the Minnesota Family Planning Program Section 1115 Demonstration Project. The demonstration project is a Medicaid waiver demonstration project approved by the Centers for Medicare and Medicaid Services to provide federally approved contraception management services to eligible low-income persons.

Statutory Authority: *MS s 256B.04*

History: *31 SR 771*

Published Electronically: *August 12, 2008*

9505.5305 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9505.5300 to 9505.5325 have the meanings given them in this part.

Subp. 2. **Applicant.** "Applicant" means a person who submits a written demonstration project application to the department for a determination of eligibility for the demonstration project.

Subp. 3. **Certified family planning services provider.** "Certified family planning services provider" means a family planning services provider that meets the requirements of part 9505.5315, subpart 1.

Subp. 4. **Commissioner.** "Commissioner" means the commissioner of human services or the commissioner's designee.

Subp. 5. **Contraception management services.** "Contraception management services" means a scope of family planning services limited to initiating or obtaining an enrollee's contraceptive method and maintaining effective use of that method.

Subp. 6. **Countable income.** "Countable income" means the income, including deemed income, used to determine a person's eligibility for the demonstration project.

Subp. 7. **County agency.** "County agency" has the meaning given in Minnesota Statutes, section 256B.02, subdivision 6.

Subp. 8. **Demonstration project.** "Demonstration project" means the Minnesota Family Planning Program Section 1115 Demonstration Project, Project Number 11-W-00183/5.

Subp. 9. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 10. **Enrollee.** "Enrollee" means a person enrolled in the demonstration project.

Subp. 11. **Family planning services provider.** "Family planning services provider" includes the providers listed in part 9505.0280, subpart 3, and clinical nurse specialists, laboratories, ambulatory surgical centers, federally qualified health centers, Indian Health Services, public health nursing clinics, and physician assistants who are authorized providers under part 9505.0195.

Subp. 12. **Family size.** "Family size" means the number of people used to determine a person's income standard. The family size includes the person and the following people who live with the person: the person's spouse, the biological and adoptive children of the person who are under age 21, and the biological and adoptive children of the person's spouse who are under age 21.

Subp. 13. **Minnesota health care program.** "Minnesota health care program" means medical assistance under Minnesota Statutes, chapter 256B, general assistance medical care under Minnesota Statutes, section 256D.03, and MinnesotaCare under Minnesota Statutes, chapter 256L.

Subp. 14. **Presumptive eligibility.** "Presumptive eligibility" means the temporary period of eligibility for the demonstration project that is determined at the point of service by a certified family planning services provider.

Subp. 15. **Qualified noncitizen eligible for medical assistance with federal financial participation.** "Qualified noncitizen eligible for medical assistance with federal financial participation" means a person that meets the requirements of Minnesota Statutes, section 256B.06, subdivision 4.

Subp. 16. **Resident.** "Resident" means a person who meets the requirements in part 9505.0030.

Statutory Authority: *MS s 256B.04*

History: *31 SR 771*

Published Electronically: *August 12, 2008*

9505.5310 DEMONSTRATION PROJECT ELIGIBILITY, APPLICATION, ENROLLMENT, AND DOCUMENTATION.

Subpart 1. **General eligibility.** The eligibility and coverage requirements in this subpart apply to applicants and enrollees.

A. Except as provided in subpart 2, an applicant or enrollee must meet the following requirements to be eligible for the demonstration project:

(1) be a citizen of the United States or a qualified noncitizen eligible for medical assistance with federal financial participation;

(2) be a Minnesota resident;

(3) be 15 years of age or older and under age 50;

(4) have countable income at or below 200 percent of the federal poverty guidelines for the family size. Countable income is determined according to the income rules applied in eligibility determinations for families and children in the medical assistance program according to Minnesota Statutes, section 256B.056, and United States Code, title 42, chapter 7, subchapter XIX, section 1396u-1, as follows:

(a) income includes all categories of earned and unearned income used in eligibility determinations for families and children under the medical assistance program;

(b) income does not include any categories of income that are excluded for purposes of determining eligibility for families and children in the medical assistance program;

(c) income methodologies, such as earned income deductions and disregards, used to determine eligibility for families and children in the medical assistance program according to Minnesota Statutes, section 256B.056, subdivisions 1a and 1c, do not apply to the determination of countable income; and

(d) income deeming requirements used to determine eligibility for families and children in the medical assistance program apply, except that for a person under age 21, no income from a parent, spouse, or sponsor is deemed to the person;

(5) not be pregnant;

(6) not be enrolled in the Minnesota health care program or other health service program administered by the department; and

(7) not be an institutionalized individual as described under Code of Federal Regulations, title 42, sections 435.1008 and 435.1009.

B. Participation in the demonstration project does not require the consent of anyone other than the applicant.

C. Asset requirements do not apply to applicants and enrollees.

D. Applicants and enrollees must report available third-party coverage and cooperate with the department in obtaining third-party payments. The department shall waive this requirement if the applicant or enrollee states that reporting third-party coverage could violate the applicant's or enrollee's privacy.

Subp. 2. **Presumptive eligibility.** Services covered under the demonstration project may be provided during a presumptive eligibility period.

A. A certified family planning services provider will screen a person for demonstration project eligibility using preliminary information provided by the person. A person who, based on the preliminary information, appears to meet the eligibility requirements in part 9505.5310, subpart 1, item A, subitems (2) to (6), is presumptively eligible for the demonstration project.

B. The presumptive eligibility period begins the first day of the month that a certified family planning services provider determines that a person is presumptively eligible. The presumptive eligibility period ends the last day of the month following the month that the certified family planning services provider determines that a person was presumptively eligible.

C. A person determined presumptively eligible must comply with part 9505.5310, subpart 1, item D.

D. A person may receive presumptive eligibility once during a 12-month period.

Subp. 3. **Enrollment.** An applicant must apply for the demonstration project using forms provided by the department.

A. The department or county agency must determine an applicant's eligibility for the demonstration project within 45 days of receipt of a completed application.

B. Except as provided in item C, eligibility begins the first day of the month of application. If a completed application form is submitted within 30 days of the request, the month of application includes the month the department or county agency receives a written request for the demonstration project consisting of at least the name of the applicant, a means to locate the applicant, and the signature of the applicant.

C. A person who is eligible under subparts 1 and 2 and files a demonstration project application during the presumptive eligibility period is eligible for ongoing coverage on the first day of the month following the month that presumptive eligibility ends.

Subp. 4. **Application and documentation.** The application and documentation requirements in this subpart apply to all applicants and enrollees.

A. An enrollee is eligible for the demonstration project for one year regardless of changes in income or family size. Eligibility will end prior to the annual renewal if the enrollee:

(1) dies;

(2) is no longer a Minnesota resident;

(3) voluntarily terminates eligibility;

(4) enrolls in the Minnesota health care program or other health service program administered by the department;

(5) reaches 50 years of age;

(6) becomes pregnant;

(7) becomes an institutionalized individual under Code of Federal Regulations, title 42, sections 435.1008 and 435.1009; or

(8) is no longer a citizen of the United States or a qualified noncitizen eligible for medical assistance with federal financial participation.

B. Applicants and enrollees must document their income at application.

C. Enrollees must complete an annual application on forms provided by the department.

D. Applicants and enrollees must provide documentation of immigration status at application. The department or county agency will verify applicant and enrollee immigration status according to Minnesota Statutes, section 256.01, subdivision 18.

E. Applicants and enrollees must report a change in an eligibility factor to the department or county agency within ten days of learning about the change. Applicants and enrollees who fail to report a change that would have resulted in ineligibility for the demonstration project will be disenrolled from the demonstration project and will be ineligible for the demonstration project for a period of 12 months following the date of disenrollment. If the only unreported change is a pregnancy, applicants and enrollees will not be subject to the 12 months ineligibility period, but pregnant applicants and enrollees will be disenrolled from the demonstration project and may reapply for the demonstration project following the end of the pregnancy.

F. Applicants and enrollees must provide information, documents, and any releases requested by the department or county agency that are necessary to verify eligibility information. An applicant or enrollee who refuses to authorize verification of an eligibility factor, including a Social Security number, is not eligible for the demonstration project, except as provided in Code of Federal Regulations, title 42, section 435.910(h)(2).

G. Applicants must document citizenship as required by the federal Deficit Reduction Act of 2005, Public Law 109-71. Persons screened for presumptive eligibility under subpart 2 are not required to document citizenship.

H. An applicant may withdraw an application according to the provisions of part 9505.0090, subpart 4.

Subp. 5. **Enrollment.** To be considered for Minnesota health care program eligibility, an enrollee must complete the department's health care application. Applicants and enrollees shall not use a demonstration project application form to apply for the Minnesota health care program. People who complete the department's health care application and are determined ineligible for the Minnesota health care program, either at application or during enrollment, may authorize a demonstration project eligibility determination using the information provided in the department's health care application and updated at required intervals.

Subp. 6. **Confidentiality.** Private data about persons screened for eligibility, applicants, and enrollees must be disclosed according to the provisions of the following statutes and rules:

A. part 1205.0500 and Minnesota Statutes, chapter 13;

B. Minnesota Statutes, sections 144.291 to 144.298;

C. Minnesota Statutes, section 144.343;

D. Code of Federal Regulations, title 45, parts 160, 162, and 164; and

E. other applicable state and federal laws, statutes, rules, and regulations affecting the collection, storage, use, and dissemination of protected, private, and confidential health and other information.

Subp. 7. **Notices.** Applicants and enrollees may arrange to receive notices in a manner other than having notices mailed to the applicant's or enrollee's home address.

Statutory Authority: *MS s 256B.04*

History: *31 SR 771; L 2007 c 147 art 10 s 15*

Published Electronically: *August 12, 2008*

9505.5315 PROVIDERS OF FAMILY PLANNING SERVICES.

Subpart 1. **Certified family planning services provider requirements.** To become a certified family planning services provider, a family planning services provider must:

A. sign the business associate agreement;

B. complete required training;

C. provide information about presumptive eligibility to interested persons;

D. help interested persons complete demonstration project applications and forms;

E. use the department's eligibility verification system to verify a person screened for demonstration project eligibility does not receive Minnesota health care program coverage;

F. determine presumptive eligibility;

G. give required notices to a person screened for eligibility;

H. promptly forward completed applications and forms to the department; and

I. cooperate with department application tracking and program evaluation activities.

Subp. 2. **Covered services.** The demonstration project covers contraception management services and certain additional medical diagnosis or treatment services that are provided within the context of a visit for contraception management services. All services covered by the demonstration project are listed in Attachment B of the Centers for Medicare and Medicaid Services Special Terms and Conditions for the Minnesota Family Planning Program Section 1115 Demonstration, Project Number 11-W-00183/5 and its amendments, which are incorporated by reference. This document can be found at the Minnesota Law Library, Judicial Center, 25 Rev. Dr. Martin Luther King Jr. Blvd., Saint Paul, Minnesota 55155. Attachment B is subject to frequent change.

Subp. 3. **Payment for services.** Family planning services providers are paid for covered services as follows:

A. No cost-sharing requirements apply to services provided under the demonstration project.

B. Payments will be made on a fee-for-service basis to providers for services provided under the demonstration project.

C. All covered services provided during the presumptive eligibility period according to part 9505.5310, subpart 2, will be reimbursed.

D. The demonstration project is the payer of last resort. The demonstration project will not cover drugs that are covered under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A).

E. Parts 9505.2160 to 9505.2245, regarding surveillance and integrity review, apply to services provided under parts 9505.5300 to 9505.5325.

Statutory Authority: *MS s 256B.04*

History: *31 SR 771*

Published Electronically: *August 12, 2008*

9505.5325 APPEALS.

Subpart 1. **Notice.** The commissioner must follow the notification procedures in part 9505.0125 if the commissioner denies, suspends, reduces, or terminates eligibility or covered health services, except as provided in subpart 3.

Subp. 2. **Appeal process.** A person aggrieved by a determination or action of the commissioner under parts 9505.5300 to 9505.5325 may appeal the department's or county agency's determination or action according to Minnesota Statutes, section 256.045, except as provided in subpart 3.

Subp. 3. **Denial of presumptive eligibility.** There is no right of appeal for a denial of presumptive eligibility.

Statutory Authority: *MS s 256B.04*

History: *31 SR 771*

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