

256B.433 ANCILLARY SERVICES.

Subdivision 1. **Setting payment; monitoring use of therapy services.** The commissioner shall promulgate rules pursuant to the Administrative Procedure Act to set the amount and method of payment for ancillary materials and services provided to recipients residing in nursing facilities. Payment for materials and services may be made to either the nursing facility in the operating cost per diem, to the vendor of ancillary services pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475 or to a nursing facility pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475. Payment for the same or similar service to a recipient shall not be made to both the nursing facility and the vendor. The commissioner shall ensure the avoidance of double payments through audits and adjustments to the nursing facility's annual cost report as required by section 256B.47, and that charges and arrangements for ancillary materials and services are cost-effective and as would be incurred by a prudent and cost-conscious buyer. Therapy services provided to a recipient must be medically necessary and appropriate to the medical condition of the recipient. If the vendor, nursing facility, or ordering physician cannot provide adequate medical necessity justification, as determined by the commissioner, the commissioner may recover or disallow the payment for the services and may require prior authorization for therapy services as a condition of payment or may impose administrative sanctions to limit the vendor, nursing facility, or ordering physician's participation in the medical assistance program. If the provider number of a nursing facility is used to bill services provided by a vendor of therapy services that is not related to the nursing facility by ownership, control, affiliation, or employment status, no withholding of payment shall be imposed against the nursing facility for services not medically necessary except for funds due the unrelated vendor of therapy services as provided in subdivision 3, paragraph (c). For the purpose of this subdivision, no monetary recovery may be imposed against the nursing facility for funds paid to the unrelated vendor of therapy services as provided in subdivision 3, paragraph (c), for services not medically necessary. For purposes of this section and section 256B.47, therapy includes physical therapy, occupational therapy, speech therapy, audiology, and mental health services that are covered services according to Minnesota Rules, parts 9505.0170 to 9505.0475, and that could be reimbursed separately from the nursing facility per diem.

Subd. 2. **Certification that treatment is appropriate.** The physical therapist, occupational therapist, speech therapist, mental health professional, or audiologist who provides or supervises the provision of therapy services, other than an initial evaluation, to a medical assistance recipient must certify in writing that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the recipient every 30 days. The therapist's statement of certification must be maintained in the recipient's medical record together with the specific orders by the physician and the treatment plan. If the recipient's medical record does not include these documents, the

commissioner may recover or disallow the payment for such services. If the therapist determines that the therapy's nature, scope, duration, or intensity is not appropriate to the medical condition of the recipient, the therapist must provide a statement to that effect in writing to the nursing facility for inclusion in the recipient's medical record. The commissioner shall utilize a peer review program that meets the requirements of section 256B.064, subdivision 1a, to make recommendations regarding the medical necessity of services provided.

Subd. 3. **Separate billings for therapy services.** Until new procedures are developed under subdivision 4, payment for therapy services provided to nursing facility residents that are billed separate from nursing facility's payment rate or according to Minnesota Rules, parts 9505.0170 to 9505.0475, shall be subject to the following requirements:

(a) The practitioner invoice must include, in a format specified by the commissioner, the provider number of the nursing facility where the medical assistance recipient resides regardless of the service setting.

(b) Nursing facilities that are related by ownership, control, affiliation, or employment status to the vendor of therapy services shall report, in a format specified by the commissioner, the revenues received during the reporting year for therapy services provided to residents of the nursing facility. For rate years beginning on or after July 1, 1988, the commissioner shall offset the revenues received during the reporting year for therapy services provided to residents of the nursing facility to the total payment rate of the nursing facility by dividing the amount of offset by the nursing facility's actual resident days. Except as specified in paragraphs (d) and (f), the amount of offset shall be the revenue in excess of 108 percent of the cost removed from the cost report resulting from the requirement of the commissioner to ensure the avoidance of double payments as determined by section 256B.47. Therapy revenues that are specific to mental health services shall be subject to this paragraph for rate years beginning after June 30, 1993. In establishing a new base period for the purpose of setting operating cost payment rate limits and rates, the commissioner shall not include the revenues offset in accordance with this section.

(c) For rate years beginning on or after July 1, 1987, nursing facilities shall limit charges in total to vendors of therapy services for renting space, equipment, or obtaining other services during the rate year to 108 percent of the annualized cost removed from the reporting year cost report resulting from the requirement of the commissioner to ensure the avoidance of double payments as determined by section 256B.47. If the arrangement for therapy services is changed so that a nursing facility is subject to this paragraph instead of paragraph (b), the cost that is used to determine rent must be adjusted to exclude the annualized costs for therapy services that are not provided in the rate year. The maximum charges to the vendors shall be based on the commissioner's determination of annualized cost and may be subsequently adjusted upon

resolution of appeals. Mental health services shall be subject to this paragraph for rate years beginning after June 30, 1993.

(d) The commissioner shall require reporting of all revenues relating to the provision of therapy services and shall establish a therapy cost, as determined by section 256B.47, to revenue ratio for the reporting year ending in 1986. For subsequent reporting years, the ratio may increase five percentage points in total until a new base year is established under paragraph (e). Increases in excess of five percentage points may be allowed if adequate justification is provided to and accepted by the commissioner. Unless an exception is allowed by the commissioner, the amount of offset in paragraph (b) is the greater of the amount determined in paragraph (b) or the amount of offset that is imputed based on one minus the lesser of (1) the actual reporting year ratio or (2) the base reporting year ratio increased by five percentage points, multiplied by the revenues.

(e) The commissioner may establish a new reporting year base for determining the cost to revenue ratio.

(f) If the arrangement for therapy services is changed so that a nursing facility is subject to the provisions of paragraph (b) instead of paragraph (c), an average cost to revenue ratio based on the ratios of nursing facilities that are subject to the provisions of paragraph (b) shall be imputed for paragraph (d).

(g) This section does not allow unrelated nursing facilities to reorganize related organization therapy services and provide services among themselves to avoid offsetting revenues. Nursing facilities that are found to be in violation of this provision shall be subject to the penalty requirements of section 256B.48, subdivision 1, paragraph (f).

Subd. 3a. **Exemption from requirement for separate therapy billing.** The provisions of subdivision 3 do not apply to nursing facilities that are reimbursed according to the provisions of section 256B.431. Nursing facilities that are reimbursed according to the provisions of section 256B.434 and are located in a county participating in the prepaid medical assistance program are exempt from the maximum therapy rent revenue provisions of subdivision 3, paragraph (c).

Subd. 4. [Repealed, 1993 c 337 s 20]

History: 1983 c 199 s 18; 1985 c 248 s 69; 1987 c 403 art 2 s 90; 1988 c 629 s 54,55; 1988 c 689 art 2 s 162; 1992 c 513 art 7 s 105-107,136; 1993 c 337 s 17; 1997 c 203 art 3 s 9; 1998 c 407 art 3 s 12; 1Sp2001 c 9 art 5 s 22; 2002 c 379 art 1 s 113