CHAPTER 9505
DEPARTMENT OF HUMAN SERVICES
HEALTH CARE PROGRAMS

MEDICAL ASSISTANCE ELIGIBILITY

9505.0010 APPLICABILITY.

Parts 9505.0010 to 9505.0150 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, 256.965, and 256.98.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

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 All persons should be aware that parts 9505.0010 to 9505.0150 of the medical assistance program may be superseded by a change in state or federal law or by a court order prior to the agency having an opportunity to amend these rules.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 9505.0150.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

9505.0015 DEFINITIONS.

Subpart 1. **Applicability.** For the purposes of parts 9505.0010 to 9505.0150, the following terms have the meanings given to them in this part.

Subp. 2. **Aid to families wth dependent children or AFDC.** "Aid to families with dependent children" or "AFDC" means the program established under Minnesota Statutes, sections 256.72 to 256.871; Code of Federal Regulations, title 45; and parts 9500.2000 to 9500.2880.

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. **Assistance unit.** "Assistance unit" means those persons living together who are applying for or receiving medical assistance and whose income and assets are considered available to each other under part 9505.0075, subparts 2 and 5. A stepparent is not included in the same assistance unit as a stepchild.

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 9505.0150 on that person's behalf.

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

Subp. 10. **County of financial responsibility.** "County of financial responsibility" means the county that is obligated to pay on behalf of a recipient the portion of the nonfederal share of the medical assistance payments for the recipient's health services and the portion of the nonfederal share of administrative costs applicable to the recipient's case as specified in Minnesota Statutes, sections 256.965, 256B.02, subdivision 3, 256B.041, subdivisions 3 and 7, and 256B.19, subdivision 1.

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. **Excluded time.** "Excluded time" means time an applicant spends in one of the facilities listed in Minnesota Statutes, section 256B.02, subdivision 2.

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, section 256B.02, subdivision 8.

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. **Living together.** "Living together" refers to the relationship of two or more persons who have the same residence. The term applies only to eligibility determinations involving spouses and eligibility determinations involving parents living with a child under age 21. The presumption that two persons who have the same residence are living together may be rebutted through submission of convincing evidence to the contrary. The following limitations also apply:

A. An absence from the residence for a period that lasts less than a full calendar month does not interrupt living together.

B. When a child alternates living together with each of his or her parents who live apart, the child is considered to live with the parent with whom it is anticipated the most time will be spent. If the child spends equal time with both parents, the child is considered to live with the parent with whom the child is living on the date of application.

C. A person and spouse who reside in the same long-term care facility do not live together regardless of whether they occupy the same room.

D. A child who has remained hospitalized without interruption for a full calendar month beginning with the day of birth is not considered to live together with the parents.

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 9505.0150 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 the mentally retarded.

Subp. 29. **Market rent.** "Market rent" means the rental income that a property would most probably command on the open market in an arm's length negotiation as shown by current rentals being paid for comparable space of comparable worth.

Subp. 30. **Market value.** "Market value" means the most probable price in terms of money that a property should bring in a competitive and open market under all conditions requisite to a fair sale. The value on the most recent property tax statement is presumed to be the market value unless the person or the local agency provides convincing evidence to overcome the presumption.

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.35 to 256D.43.

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

Subp. 35. **Net income from rental property.** "Net income from rental property" means the remainder after subtracting the deductions in part 9505.0065, subpart 8, from gross rental income produced by property.

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. **Responsible relative.** "Responsible relative" means the spouse of a medical assistance recipient or applicant or the parent of a child under age 18 who is a medical assistance recipient or applicant.

Subp. 44. **Spend-down.** "Spend-down" 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 Health Care Financing Administration 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 provid-

ing 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 subd 2*

History: *11 SR 1069*

9505.0016 AUTOMATIC MEDICAL ASSISTANCE ELIGIBILITY.

A person receiving public assistance as in part 9505.0055 is eligible for medical assistance without further determination provided the person complies with parts 9505.0070 and 9505.0071. However, a person who is not eligible for public assistance may apply for and shall be granted medical assistance if the person meets the requirements of parts 9505.0010 to 9505.0150.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

9505.0020 CITIZENSHIP REQUIREMENT.

Eligibility for medical assistance is limited to citizens of the United States and to aliens lawfully admitted for permanent residence or otherwise permanently residing in the United States under the color of the law.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

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. **County of financial responsibility.** Except as provided in items A to D, the county of the applicant's residence on the date of application is the county of financial responsibility. If the prior residence was not in a Minnesota county, or the county of residence cannot be determined, the county of residence is the county in which the person is residing at the time of application.

A. If the applicant's current residence falls within the definition of excluded time, the county of financial responsibility is the county of the applicant's residence immediately before the applicant began his or her current residence.

B. An infant who has resided only in a facility falling within the definition of excluded time is the responsibility of the county that would have been responsible if eligibility could have been established with the birth mother at the time of the birth.

C. The county which is financially responsible for a person who is a recipient of aid to families with dependent children, Minnesota supplemental aid, or general assistance is also the county of financial responsibility for that person's medical assistance.

D. A person's county of financial responsibility remains the same until the person is ineligible for medical assistance for more than one calendar month.

Subp. 3. **Dispute about county of financial responsibility.** Eligibility must not be delayed or denied because of a dispute over the determination of the county of financial responsibility. The local agency in the county of service must take the person's application and determine eligibility of the person, and open the case if the person is found eligible. A local agency involved in a dispute about the county of financial responsibility may request a written determination about the county of financial responsibility from the department. A local agency may appeal the written determination of the department to the district court under Minnesota Statutes, section 256.045.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

9505.0040 AGE AND HEALTH REQUIREMENTS.

Eligibility for medical assistance is limited to persons described in items A to K:

A. A person under 21 years of age.

B. A person 21 years of age but less than 22 years of age who has been receiving inpatient psychiatric care continuously since his or her 21st birthday.

C. A person at least 65 years of age.

D. A person who satisfies the requirements of the aid to families with dependent children program in regard to caretaker relative status.

E. A person determined to be disabled for purposes of the retirement survivors and disability or supplemental security income program.

F. A person determined to be disabled by the department's state medical review team.

G. A person determined to be legally blind by a licensed physician or licensed optometrist on the basis of having a field of vision no greater than 20 degrees or best corrected visual acuity of 20/200 or less.

H. A person who has received or has been eligible to receive medical assistance as a disabled or blind person for each consecutive month since December 1973.

I. A woman whose pregnancy is certified by a physician or certified nurse midwife and who except for income and assets would be eligible for the aid to families with dependent children program if the child was born. Status in this category begins on the first day of the month of the estimated date of conception and ends 60 days postpartum.

J. A woman whose pregnancy is certified by a physician or certified nurse midwife and whose unborn child would be eligible for medical assistance if the child was born. Status in this category begins on the first day of the month of the estimated date of conception and ends 60 days postpartum.

K. Notwithstanding parts 9505.0010 to 9505.0150, a child born on or after October 1, 1984, is automatically eligible for one year following birth if the mother remains a recipient and the child lives with the mother.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

9505.0044 INFORMATION ABOUT SOCIAL SECURITY NUMBER.

An applicant, the applicant's authorized representative, or the applicant's responsible relative shall give the local agency the applicant's social security number at the time of application for medical assistance. A person who does not have a social security number at the time of application must apply for a number in order to be eligible for medical assistance. However, a child eligible for medical assistance under part 9505.0040, item K, is not required to apply for a social security number while the child remains eligible under item K.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

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 he or she is receiving inpatient psychiatric care in a psychiatric facility accredited by the joint commission on accreditation of hospitals, and meets one of the conditions listed in part 9505.0040, items A to C. Notwithstanding the other provisions of parts 9505.0010 to 9505.0150, 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 subd 2*

History: *11 SR 1069*

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 subd 2*

History: *11 SR 1069*

9505.0055 EFFECT OF PUBLIC ASSISTANCE STATUS ON MEDICAL ASSISTANCE ELIGIBILITY.

Subpart 1. **Recipient of AFDC or MSA.** A person who is a recipient of aid to families with dependent children is eligible for medical assistance. A person who is a recipient of Minnesota supplemental aid is eligible for medical assistance, except for those persons eligible for Minnesota supplemental aid because the local agency waived excess resources under the Minnesota supplemental aid provisions.

Subp. 2. **Suspension from AFDC.** A person suspended from aid to families with dependent children remains eligible for medical assistance during the period of suspension when the suspension is caused by receipt of an extra paycheck or other temporary increase in earned income.

Subp. 3. **Termination from AFDC.** A person terminated from aid to families with dependent children remains eligible for medical assistance under the conditions in items A to C:

A. If termination from aid to families with dependent children was caused by an increase in the person's wages or hours of work, or by an increase in the amount of child support payments, the person remains eligible for medical assistance for four months after termination if the person received aid to families with dependent children in at least three of the six months immediately before termination of the grant and the person's increased earned income or child support continues for the four-month period.

B. If termination from aid to families with dependent children was

caused by the person's loss of the disregard of $30 or the disregard of $30 and one-third of earned income, the person remains eligible for nine months after termination. The person is also eligible for an additional three months after the nine months if the local agency determines that the assistance unit would remain eligible for aid to families with dependent children if the disregard of $30 or $30 and one-third was applied to the earned income.

C. If termination from aid to families with dependent children was caused by deeming or allocating income of stepparents, grandparents, or siblings, the person must be given a termination notice allowing one month of medical assistance eligibility after the termination of aid to families with dependent children. In order to remain continuously eligible for medical assistance beyond the one month, the person must be eligible under parts 9505.0010 to 9505.0150 and must return the application supplied with the termination notice within ten days after the effective date of the termination.

Subp. 4. **Adopted children.** A child under age 18 whose adoption is subsidized by state funds under Minnesota Statutes, section 259.40 or funds from title IV-E of the Social Security Act is eligible for medical assistance upon application and verification of subsidized adoption status. The local agency shall request the adoptive parent to comply with the requirements of parts 9505.0070 and 9505.0071.

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 subd 2*

History: *11 SR 1069*

9505.0058 ASSETS; HOMESTEAD AND HOUSEHOLD GOODS AND FURNITURE.

Subpart 1. **General exclusion.** Except as provided in subpart 2, a person's homestead as defined in Minnesota Statutes, section 256B.06, subdivision 1, and household goods and furniture used in the person's residence must be excluded from consideration as assets.

Subp. 2. **Exclusion for person residing in long-term care facility.** The homestead of a person residing in a long-term care facility is excluded if the homestead is used as a primary residence by the person's spouse, the person's child under age 18, or the person's disabled child of any age. The homestead is also excluded for the first six calendar months of the person's stay in the long-term care facility. The local agency shall notify the person in writing that the homestead must be reduced to an amount within limits or excluded on another basis if the person expects to remain in the long-term care facility for a period longer than six months. The agency must give this notice at the later of the time when the person enters the facility or the determination of eligibility, but no later than the last day of the fifth month of the person's stay in the facility.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

9505.0059 ASSETS; REAL PROPERTY OTHER THAN HOMESTEAD.

Subpart 1. **Definitions.** For the purposes of parts 9505.0059 to 9505.0064, the following terms have the meanings given to them in this part.

A. "Equity" means the property's current market value less any encumbrances.

B. "Not salable" means that:

(1) two sources agree that the property is not salable due to a specified condition; or

(2) an actual sale attempt was made at a price not more than an estimate of the highest current market value obtained within six months of application or since the last determination of eligibility, but no offer to purchase was received.

For purposes of subitems (1) and (2), the source of information must be from the same geographic area as the property and knowledgeable about the value of the type of property offered for sale. For purposes of subitem (2), "an actual sale attempt" means the individual has listed the property with a licensed real estate broker or salesperson or, if the property is offered for sale by the owner, the owner has affixed to the property a readable sign that includes the address or phone number of the owner and the owner has advertised the property for sale in the official newspaper of the county, the newspaper of largest circulation in the county or the local shopper. For purposes of subitem (2), the minimum period of an actual sale attempt shall be 90 consecutive days.

Subp. 2. **Consideration of real property.** A person who owns real property is not eligible for medical assistance unless the property is excluded from consideration as an asset under subpart 3 or part 9505.0058.

Subp. 3. **Exclusions other than homestead and household goods and furniture.** Real property in items A to D must be excluded from consideration as an asset.

A. Real property that is rental property as defined in part 9505.0015, subpart 35, is leased at a market rent, and produces a net income provided the amount of the person's equity in the property is less than $6,000 and the net income received by the person is at least six percent of the amount of the person's equity.

B. Real property on or in which the person operates a business that is anticipated to produce a net income under part 9505.0065, subpart 9 provided the amount of the person's equity in the property is less than $6,000 and the net income received by the person is at least six percent of the amount of the person's equity.

C. Real property that is not salable.

D. Real property other than property in items A to C if the equity in the real property when combined with the equity in the homestead does not exceed $15,000.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

9505.0060 ASSETS; PERSONAL PROPERTY.

Subpart 1. **Definition.** For purposes of this part, "personal property" means all property other than real estate. Examples are cash including savings and checking accounts; cash surrender value of insurance; prepaid burial accounts; individual retirement or Keogh accounts; stocks and bonds; certificates of deposit; investments in diamonds, gold, and other precious metals or jewels; trust funds; motor vehicles; boats and recreational vehicles; livestock; business inventory and equipment; lump sum payments; contracts for deed; windfalls; gifts and inheritances other than real estate; and retroactive payments of benefits from Social Security or the Veterans Administration.

Subp. 2. **Consideration of personal property; general.** A person who owns personal property in excess of the limits established in Minnesota Statutes, sections 256B.06, subdivision 1, clause (13) and 256B.07 and this part is not eligible for medical assistance unless the personal property is exempt from consideration as an asset.

Subp. 3. **Consideration of trust funds.** Trust funds shall be considered available as specified in items A to C. The trusts must also be evaluated under part 9505.0064.

A. A beneficiary's interest in a trust fund is subject to the personal property limitation under Minnesota Statutes, section 256B.06, subdivision 1, clause (13) and is considered to be available unless it can be affirmatively demonstrated through court order that the trust fund cannot be made available to meet the individual's medical needs. If the county attorney advises the local agency that the money cannot be made available and the agency decides not to pursue court action, the local agency shall refer the matter to the department.

B. Trusts established other than by will by the person or the person's spouse under which the person may be the beneficiary of all or part of the payments from the trust and the distribution of the payments is determined by one or more trustees who may exercise discretion about the distribution to the person shall be considered available assets. This item applies regardless of whether the trust is irrevocable or is established for purposes other than to enable a person to qualify for medical assistance or whether the discretion of the trustees is exercised.

C. A trust fund established by the person on behalf of another individual within 24 months before application or during a period of eligibility shall be considered a transferred asset under part 9505.0064.

Subp. 4. **Personal property exempt from consideration.** The following items of personal property are exempt from consideration:

A. Liquid assets in the amount specified in Minnesota Statutes, section 256B.06, subdivision 1, clause (13).

B. The person's wearing apparel and personal jewelry.

C. One motor vehicle as defined in Minnesota Statutes, section 256B.06, subdivision 1, clause (13)(b) and used primarily for the person's benefit, and that:

(1) has a market value of less than $4,500; or

(2) is necessary to obtain medically necessary health services; or

(3) is necessary for employment; or

(4) is modified for operation by or transportation of a handicapped person; or

(5) is necessary to perform essential daily tasks because of climate, terrain, distance, or similar factors. Other motor vehicles are counted to the extent of the person's equity against the asset limit in item A.

D. Cash received from the sale of a person's homestead that is applied to the purchase of another homestead within 90 days.

E. One burial plot and inscribed gravemarker for the person and each legal dependent of the person.

F. Capital and operating assets of a trade or business that the local agency determines is necessary to the person's ability to earn an income. Examples are machinery, livestock, business inventory, and equipment.

G. Real property being sold on a contract for deed to the extent the net present value of the contract in combination with other liquid assets does not exceed the limitations in item A or the contract is not salable.

H. Insurance settlements to repair or replace damaged, destroyed, or stolen property that is exempt from consideration. These settlements are excluded for a period of six months.

Subp. 5. **Separate account for excluded funds.** Funds excluded from consideration as an asset by parts 9505.0058 to 9505.0062 and 9505.0065 must be placed in an account separate from other accounts in order to retain the exclusion. Upon application and redetermination of eligibility, the local agency must inform the person in writing of the requirement to place the excluded funds in a separate account.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

9505.0061 ASSETS; AVAILABILITY.

In addition to assets considered available under parts 9505.0058 to 9505.0064, the local agency must consider assets as specified in items A to E.

A. The local agency may not consider any asset while the asset is not available to the person. Examples of an asset not available to a person are an estate that has not been probated; property owned together with one or more other individuals which the local agency determines cannot be liquidated or reduced to cash through the exercise of the person's legal rights; an asset of a person who is determined incompetent by the court and whose guardianship is pending; and an asset frozen by a foreign government.

B. A local agency must consider as available an asset that has been transferred without adequate compensation as described in part 9505.0064.

C. A local agency must consider as available an asset that the person has failed to make available for purposes of medical assistance eligibility. An example of a person's failure to make an asset available occurs when the person refuses to accept his or her share of an inheritance.

D. A local agency must consider as available an asset that a person receives in a tort settlement, whether the settlement is entered into by the person or the person's guardian, that is structured to be paid over a period of time. The local agency shall evaluate the asset on the basis of the discounted net present value of all funds that will be deposited at any time in the future. In determining present value, an annual interest rate of six percent shall be used. This item applies only to a structured settlement entered into after the effective date of this item. The period of ineligibility resulting from the value of a structured settlement shall be calculated according to part 9505.0064, subpart 2, item C.

E. The local agency must consider as available an individual retirement or Keogh account. The local agency shall evaluate individual retirement and Keogh accounts on the basis of the funds deposited in the account and the interest accrued on the funds less the penalty for early withdrawal.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

9505.0062 ASSETS; JOINT TENANCY; LIFE ESTATE.

Subpart 1. **Asset in joint tenancy.** The owner of an asset in joint tenancy must be considered to own an equal share of the value of the asset, but the local agency or the joint tenant may prove ownership of a greater or lesser amount. An owner of an asset as a tenant in common owns a prorata share of the property value.

Subp. 2. **Valuation of property held in life estate.** Ownership of a life estate is ownership of real property and makes a person ineligible for medical assistance unless the life estate is excluded from consideration as an asset under parts 9505.0058 and 9505.0059. The value of the life estate is determined by multiplying the amount of the equity of the real property by the value listed on Table A, Single Life, Unisex, Ten Percent, showing the present worth of an annuity, of a life interest, and of a remainder interest, found at Code of Federal Regulations, Title 26, section 20.2031-7, for the age of the holder of the life estate. The holder of the life estate is entitled to all rental income produced by the life estate. The rental income is computed according to part 9505.0065, subpart 7. If the property is sold not subject to the life estate, the proceeds of the sale attributed to the holder of the life estate are the price for which the property was sold less any encumbrances and reasonable sale costs multiplied by the value listed on Table A, Single Life, Unisex, Ten Percent, showing the present worth of an annuity, of a life interest, and of a remainder interest, for the age of the holder of the life estate.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

9505.0063 EXCESS ASSETS.

Subpart 1. **Reduction of excess assets.** Assets in excess of the limits in parts 9505.0058 to 9505.0062 may be reduced as in items A to D so that a person is eligible for medical assistance.

A. If the assets of an applicant seeking retroactive eligibility under part 9505.0110, subpart 1 exceed the limits in parts 9505.0058 to 9505.0062, the applicant may apply the excess assets toward health service bills incurred in the retroactive period, that is, in the three calendar months before the month of application. When the excess is spent, the applicant's eligibility begins with the next dollar of health service bills incurred in the retroactive period. The applicant shall first spend excess assets to pay health service bills and then spend down income as required in part 9505.0065, subpart 11.

B. If the assets of an applicant seeking eligibility beginning in the month of application exceed the limits in parts 9505.0058 to 9505.0062, the applicant may reduce the assets to within limits by paying bills for health services that would otherwise be paid by medical assistance or by a means other than a transfer of property prohibited under part 9505.0064.

C. If the assets of a recipient increase in value beyond the limits in parts 9505.0058 to 9505.0062, the recipient must report the excess assets to the local agency within ten days. Upon notice of excess assets, the local agency shall issue a notice of termination according to part 9505.0125, subpart 1, item C. The recipient remains eligible for medical assistance only if he or she:

(1) uses the excess to repay the state or local agency for medical assistance already received; or

(2) reduces the excess by a means other than a transfer of property prohibited under part 9505.0064.

To remain eligible, the recipient must take one of these steps and notify the local agency before the effective date of the notice of termination.

D. Health service bills used to reduce excess assets in items A and B must not be used to meet income spend-down requirements.

Subp. 2. **Interim assistance pending reduction of excess real property.** The amount of a person's equity in real property that is not excluded under parts 9505.0058 and 9505.0059 and which is legally available must be applied against the limits in part 9505.0060. When the amount of the person's equity exceeds the limits in part 9505.0060, the applicant or recipient may qualify to receive nine months of assistance if he or she makes a good faith effort to sell the property and signs a legally binding agreement to repay the amount of assistance issued during that nine months. If the property is sold during the nine months and the net proceeds are less than the amount of the assistance issued, the amount that must be repaid shall be the net proceeds from the sale. If the property is sold after the nine-month period, the full amount of assistance received during the nine-month period must be considered an overpayment and is subject to recovery by the department.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

9505.0064 TRANSFERRED ASSETS.

Subpart 1. **Transferred assets; general.** A person's own assets must be used to pay for the person's health services until the assets are reduced to within the limits in parts 9505.0058 to 9505.0060. The value of an asset that is not excluded under parts 9505.0058 to 9505.0060 and that a person or the person's authorized representative transfers or sells for less than market value within the 24 months preceding application or during the period of medical assistance eligibility shall be considered available as an asset in determining the person's eligibility.

A transfer of a nonexcluded asset for less than market value within 24

months preceding application or during the period of medical assistance eligibility is presumed to be for the purpose of establishing or maintaining medical assistance eligibility, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. Convincing evidence must include evidence that the person had no health or economic reason to believe that public money would be needed for health service bills or that nursing home care would be needed. A transfer for purposes of preserving an estate for heirs is the same as a transfer for the purpose of establishing or maintaining medical assistance eligibility.

Subp. 2. **Treatment of transferred assets.** Transfers of assets must be treated as follows:

A. An applicant must declare any transfer or sale of an asset that took place within 24 months preceding the application. An applicant whose application is pending or a recipient must declare all asset transfers or sales within ten days of the transfer or sale.

B. A person who has transferred or sold an asset shall provide the local agency a description of the asset, the encumbrances on the asset, its market value at the time of the transfer or sale, the name of each entity who received the asset, the specific circumstances under which the asset was transferred or sold, and the amount and kind of compensation received.

(1) For purposes of this item, the value of the transferred or sold asset that will be applied against the person's asset limitation is the market value at the time of the transfer or sale less the encumbrances on the asset and the compensation received.

(2) Services must not be considered compensation for transfer or sale of an asset unless the compensation was stipulated in a notarized written agreement which was in existence when the service was performed. The agreement must state the service performed and the rate of reimbursement. The rate of reimbursement must be consistent with a charge for a similar service performed in the community. For purposes of this subitem, "services" means labor performed by one individual for another individual or entity.

(3) Goods are not considered compensation unless supported by contemporaneous receipts or other evidence of expenditure.

(4) Purchase of paid-up life insurance with no cash surrender value available to the person while the person is a recipient of medical assistance or within 24 months before application for medical assistance must be considered a transfer of an asset without adequate compensation under this subpart.

C. A person who has transferred or sold a nonexempt asset without receiving adequate compensation as in this subpart is ineligible for medical assistance as specified in subitems (1) to (4):

(1) The total amount transferred in any month must be considered a single transfer.

(2) The number of calendar months of ineligibility must be calculated by dividing the amount transferred by the statewide average monthly per person rate for skilled nursing facilities determined under part 9510.0010 [Emergency]. For a partial month of ineligibility, the amount transferred shall affect eligibility by a reduction in the amount of medical assistance for the first month of eligibility equal to the fractional amount. The average rate per person used must be that in effect for the completed calendar year before the month of application or the most recent redetermination under part 9505.0115. The period of ineligibility begins with the later of the month of the transfer or the month in which the transfer becomes known to the local agency if the transfer was not reported at the time of application or when it occurred.

(3) If a person makes transfers in more than one month, the ineligibility period for each transfer must be calculated independently. When multiple

transfers result in overlapping periods of ineligibility, the total length of the period of ineligibility is the sum of the periods.

(4) The person remains ineligible until the calculated ineligibility period expires. Reapplication does not affect ineligibility periods.

D. A homestead transferred or sold for less than adequate compensation as in item B by a recipient or applicant who currently resides in a long-term care facility or a person who enters a long-term care facility within 24 months of the sale or transfer shall be considered available as an asset unless one of the conditions in subitems (1) to (4) applies:

(1) The person's attending physician certifies that the person can reasonably be expected to resume permanent residence outside of a long-term care facility within six calendar months after entering the long-term care facility. The prognosis must be in writing from the person's physician.

(2) Title to the home was transferred to the person's spouse, child who is under age 21, or child who is blind or permanently and totally disabled as defined by the medical assistance program in part 9505.0040, items E, F, G, and H.

(3) A satisfactory showing is made that the person intended to dispose of the home at market value or for other consideration equal to market value.

(4) The local agency determines that denying eligibility would cause an imminent threat to the person's health and well-being. The denial of medical assistance must not be construed as such a threat if care of the person will be provided through other means.

When eligibility has been granted under this subitem, a cause of action exists against the person or persons who received the transferred property.

The conditions in this item apply to real property that was a person's homestead at the time the person entered a long-term care facility, even if the homestead is excluded on another basis after the person has entered the long-term care facility.

E. Notwithstanding any other provision of this subpart, an applicant residing in a long-term care facility may transfer liquid assets to his or her spouse if the conditions in subitems (1) to (3) are satisfied:

(1) the spouse is not a medical assistance applicant or recipient;

(2) the amount transferred, when added to the spouse's liquid assets totals $10,000 or less at the time of the transfer; and

(3) the transfer occurs between the first of the month before the month of application and the later of 15 days after the date the local agency notifies the applicant of the need to reduce assets to gain eligibility, or the date of the local agency's action on the application. For purposes of this subitem, "application" means the initial approved application.

Subp. 3. **Consideration of loans as transfers of property.** An applicant or recipient who lends property is considered to have transferred the property. The local agency shall evaluate the transaction as a transfer of property under subparts 1 and 2. If the person receives adequate compensation for the loan or the person made the loan more than 24 months before the person's application for medical assistance, the local agency shall examine the terms of the loan for recall rights. Adequate compensation must be shown by a written loan agreement and receipt of payments according to the schedule in the agreement. If the loan is payable on demand, is due, or is otherwise negotiable, the property is presumed to be an available asset to the person. This presumption may be overcome by convincing evidence presented by the person that the loan will not be repaid. Interest payments made by the borrower to the person are considered income in the month received and an asset if retained. Principal payments made by the borrower to the person are considered as assets.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

9505.0065 INCOME.

Subpart 1. **Income eligibility standard.** The income standard for medical assistance eligibility is an annual net income based on family size according to Minnesota Statutes, section 256B.06, subdivision 1, clause (14). The family size for this subpart is the sum of all persons in the assistance unit plus the other persons who reside with the applicant or recipient, for whom the applicant or recipient is responsible, and whose income is considered available under part 9505.0075. The conditions in items A to C must be considered in determining the eligibility of the person:

A. An applicant or recipient shall apply for all benefits that will increase his or her net income as determined for medical assistance eligibility or assist in the payment of health service expenses. Examples are veterans administration aid and attendance allowance, workers' compensation benefits, annuities, pensions, and other benefits for which a person may be eligible upon application.

B. Net income above the medical assistance program standard set according to Minnesota Statutes, section 256B.06, subdivision 1, clause (14), is presumed to be available to meet health service expenses. A person with an annual net income above the standard may qualify by meeting a spend-down.

C. All income unless excluded under subpart 3 must be counted in the calendar month received. Income becomes an asset if it is retained beyond the month in which it is received, unless this part specifically states otherwise.

Subp. 2. **Calculation of net income.** Net income of an applicant, a recipient, a member of an assistance unit, and the assistance unit must be calculated as specified in items A to F.

A. Calculate separately gross earned income, gross unearned income, and gross self-employment income.

B. Subtract income that is excluded under subpart 3 as appropriate from gross earned income, gross unearned income, or gross self-employment income.

C. Subtract from gross earned income remaining after item B is completed, the earned income disregards allowed under subpart 4, and applicable employment expenses allowed under subparts 5 and 6.

D. Subtract from gross self-employment income remaining after item B is completed, applicable deductions allowed under subparts 7, 8, and 9.

E. Add together the amounts calculated in items C and D. This sum is the net income of the individual applicant, recipient, or member of the assistance unit.

F. Add together the net income of all members of the assistance unit and persons whose income is considered available under part 9505.0075, subparts 2 and 5. This sum is the net income of the assistance unit and is used in determining whether the assistance unit meets the income eligibility standard under subpart 1.

Subp. 3. **Excluded income.** Income in items A to T must be excluded from consideration as income available to meet health service needs:

A. Public assistance payments under the following programs must be excluded: aid to families with dependent children, general assistance, Minnesota supplemental aid, supplemental security income including all income of those persons deemed eligible for supplemental security income under section 1619 A and B of the Social Security Act, food stamps, title XX of the Social Security Act (if not earned income), family subsidy program under Minnesota Statutes, section 252.32 and child welfare relief. The payments must be excluded as income in the month of receipt but counted as an asset if retained after the month of receipt.

B. Casual earning or benefit received or available, including unanticipated income that totals less than $30 per month, must be excluded as income in the month of receipt but counted as an asset if retained after the month of receipt. "Casual earning or benefit" means income that is not anticipated income and that is received on an irregular or infrequent basis for services performed at irregular intervals. Examples are income from baby-sitting, the sale of blood, lawn mowing, cutting wood, and garage sales.

C. Interest paid or credited to an account within the asset standard in part 9505.0060, subpart 4, item A must be excluded as income in the month of receipt but counted as an asset if retained after the month of receipt.

D. Wages, stipends, and reimbursement for mileage and meals paid to persons working with Volunteers in Service to America (VISTA), University Year for Action, retired senior volunteer program, foster grandparents' program, service corps of retired executives, active corps of executives, and the older Americans community service program (senior companions) must be excluded as earned or unearned income in the month of receipt but counted as an asset if retained after the month of receipt.

E. Payments other than wages or salaries made to persons working in congregate meal programs or the older Americans social service employment program under the Comprehensive Older Americans Act must be excluded as income in the month of receipt but counted as an asset if retained after the month of receipt.

F. Job Training Partnership Act (JTPA) payments shall be treated as in subitems (1) and (2):

(1) An incentive allowance must be excluded as income in the month received but counted as an asset if retained after the month of receipt. For purposes of this subitem "incentive allowance" means a flat weekly amount paid to a person receiving public assistance.

(2) Training allowances and educational expenses must be deducted, and the remainder must be considered income in the month received but counted as an asset if retained after the month of receipt. For purposes of this subitem, "training allowance" means an hourly minimum wage paid to a person not receiving public assistance.

G. The earned income of a full-time student under age 18 must be excluded as income in the month received but counted as an asset if retained after the month of receipt.

H. Federal low income heating assistance program payments must be excluded as income and as an asset.

I. Foster care payments to persons who provide child and adult foster care must be excluded as income in the month of receipt but counted as an asset if retained after the month of receipt.

J. Work incentive (WIN) program work and training allowances must be excluded as income in the month of receipt but counted as an asset if retained after the month of receipt.

K. Payments for foster care and adoptions subsidized under Minnesota Statutes, section 259.40 or under title IV-E of the Social Security Act must be excluded as income and as an asset.

L. Money borrowed by the person under the terms of a written loan agreement that has a repayment schedule must be excluded as income in the month of receipt but counted as an asset if retained after the month of receipt.

M. All reverse mortgage proceeds received under Minnesota Statutes, section 47.58 must be excluded as income in the month of receipt but counted as an asset if retained after the month of receipt.

N. Payments made by federal agencies under a presidential disaster

declaration must be excluded as income in the month of receipt and as an asset for nine months after the month of receipt if kept in a separate account.

O. Funds administered by the United States secretary of education must be excluded in the month of receipt. To retain the exclusion beyond the month of receipt, the fund must be kept in a separate account. Examples of such a fund are Pell grants, supplemental educational opportunity grants, national direct student loans, federally insured student loans, and payments under the federal college work study program.

P. Payments to Indians of tribal earnings as determined by the United States Congress and Indian claims commission funds distributed on a per capita basis or held in trust must be excluded as income in the month of receipt and as an asset after the month of receipt, if the retained funds are kept in a separate account.

Q. Other educational benefits, including loans, grants, stipends, or veterans benefits must be excluded only to the extent that the amount of the benefit equals actual educational expenses. For purposes of this item, "educational expenses" refers to tuition, mandatory fees, course and laboratory fees, books, transportation to and from school, supplies, and equipment required for coursework, and child care costs incurred while at school and in transit.

R. In-kind benefits must be excluded as income and as an asset.

S. The first $50 of child support income received by the assistance unit must be excluded as income.

T. The amount of Retirement, Survivors, and Disability Insurance cost of living increases that have occurred since April 1, 1977, must be disregarded for persons who simultaneously received Retirement, Survivors, and Disability Insurance and supplemental security income or Retirement, Survivors, and Disability Insurance and Minnesota supplemental aid and would currently qualify for supplemental security income or Minnesota Supplemental aid but for the Retirement, Survivors, and Disability Insurance cost of living increases paid after April 1, 1977. The Retirement, Survivors, and Disability Insurance cost of living disregard for these persons applies also to the Retirement, Survivors, and Disability Insurance income of their spouses and dependent children.

U. Any other type of funds excluded as income or assets by federal or state law related to medical assistance must be excluded as income or assets.

Subp. 4. **Earned income disregards.** A recipient who qualifies for more than one disregard in items A to C must choose one disregard to be applied to monthly gross earned income. The disregards in items A to C also apply to the income of a spouse living with a person who is qualified for a disregard.

A. The first $20 of earned income plus one-half of the remaining monthly earned income, up to a maximum disregard of $50, for a recipient who is at least 65 years of age and does not reside in a long-term care facility.

B. The first $7.50 of gross monthly earned or unearned income plus $85 and one-half of the remaining monthly earned income for a person who is certified as blind and does not reside in a long-term care facility.

C. The first $65 plus one-half of the remaining monthly earned income for a person who is certified as disabled and does not reside in a long-term care facility.

Subp. 5. **Deduction for employment expenses of person who is age 65 or older, blind, or disabled.** The local agency shall deduct the employment expenses in the order in items A to M in determining net earned income of an employed person who is eligible because of age, blindness, or disability:

A. State and federal income taxes consistent with the number of allowable exemptions.

B. Federal insurance contributions act payments (FICA).

C. Mandatory retirement fund payments.

D. The cost of transportation related to employment. For the person who uses public transportation or takes part in a car pool, the local agency shall deduct the fare or fee the person actually pays. For the person who uses a private vehicle, the local agency shall deduct the amount per mile allowed on the most recent federal income tax return for actual miles driven for business purposes.

E. Actual reasonable expenses of child care necessary to earn income and paid to anyone other than a parent of the child or a person in the assistance unit receiving or applying for medical assistance.

F. Unreimbursed costs of transportation to and from place of child care necessary to earn income.

G. Union dues.

H. Professional association dues required for employment.

I. Health and dental insurance premiums whether mandatory or voluntary.

J. Cost of uniforms, tools, and equipment used on the job that are required, but not furnished by the employer.

K. One dollar per work day for the cost of meals during employment hours for each day the person is employed.

L. The cost of required public liability insurance that is not reimbursed by the employer.

M. Court-ordered support payments paid directly by the person or withheld by the employer and transferred to a child not living with the person or to a former spouse of the person.

Subp. 6. **Deductions for employment expenses for families and children.** In calculating the net earned income of families and children, the local agency shall deduct the greater of the sum of actual expenses of employment as calculated under subpart 5 or the amount allowed for employment expenses under the aid to families with dependent children program.

Subp. 7. **Deductions from rental income.** In calculating net rental income, the local agency shall deduct the rental property costs in items A to C from total rental receipts. The total rental receipts and the rental property costs must be prorated according to the shares of ownership if the property is jointly owned. Money deducted from rental income under items A to C must be excluded as income in the month of receipt and as an asset if the funds are retained after the month of receipt. The retained funds must be placed in a separate account until used for a purpose specified in items A to C:

A. for upkeep and repairs, an annual amount equal to a maximum of two percent of the property's market value or a lesser amount as requested by the person;

B. taxes, premiums for insurance on the property, and mortgage or contract for deed payment of interest and principal; and

C. utilities specified as the owner's responsibility in the rental agreement.

Subp. 8. **Deductions from self-employment income.** In calculating net self-employment income, the local agency shall deduct from the total business receipts the costs of producing the income as allowed on the United States income tax schedule. However, capital expenditures, depreciation, and carryover losses claimed for business purposes on the most recent federal income tax return are not deductible business expenses.

Net self-employment income, if greater than zero, must be added to other earned and unearned income to determine income for purposes of the medical assistance program. Losses from self-employment income may not be deducted from other earned or unearned income.

Subp. 9. **Deductions from income from in-home lodging or day care.** In calculating net income from a business providing lodging or day care in the person's residence, the local agency must use the methods in items A and B:

A. When the business provides room or room and board, the agency shall deduct from the monthly business income $71 per month for a roomer, $86 for each boarder, and $157 per month for an individual who receives room and board. These amounts must be adjusted as necessary to be consistent with the corresponding amounts in the aid to families with dependent children program.

B. When the person provides day care in the person's residence, the person may compute the income from the business by either:

(1) deducting itemized business expenses from gross business receipts in the manner in subpart 8; or

(2) considering net income from the child care business to be 40 percent of gross business receipts, minus the actual cost of transportation expenses incurred in operating the business.

Subp. 10. **Anticipating income.** Income must be anticipated on a semiannual basis for all persons except for a person who is on a monthly spend-down under subpart 11, items A and B. Income must be anticipated on a monthly basis for a person who is on a monthly spend-down.

Anticipated income must be determined by using the method in items A to G that most accurately reflects the circumstances of the person:

A. When income is unvarying in amount and timing of receipt, an eligibility statement or wage stub must be used to verify the amount of the income. Examples of unvarying income are social security payments, pensions, unemployment compensation, and fixed salaries. For purposes of this item, "eligibility statement" means a document from a payer informing the person of eligibility for the amount of the income.

B. Income that is expected to fluctuate slightly must be anticipated by using the income in the month of application or redetermination.

Monthly income must be calculated by multiplying:

(1) average weekly income by 4.3;

(2) average biweekly income by 2.16; or

(3) average semimonthly income by 2.

C. If income is expected to fluctuate but does not follow a seasonal pattern, monthly income is the average of monthly income received during the three most recent months.

D. If income fluctuates within a seasonal pattern, but is reasonably stable year to year, monthly income is the average of monthly income during the most recently completed calendar year.

E. Except as provided in item G, monthly farm income is the average of monthly income for the three most recent years during which the farm has been in operation.

F. Zero income must be used for any month in which no source of income is reasonably certain.

G. If the applicant or recipient has had a recent financial change that makes a method in item C, D, or E an inaccurate predictor of future income, the local agency shall make a reasonable estimate of future income and document the income basis used.

Subp. 11. **Eligibility based on income spend-down.** A person determined eligible on the basis of a spend-down is eligible for the periods specified in items A to G if the person incurs health service bills at least equal to the amount of the spend-down during the eligibility period. Except as in items C and D, only bills for health services incurred during the eligibility period may be used to satisfy the spend-down. Actual rates charged for the health service to the person less any

portion of the bill covered by a liable third party payment shall be used in determining whether the person satisfies the spend-down. Prior authorization requirements and medical assistance payment rates and service limitations under parts 9500.0900 to 9500.1080 shall not apply to health service bills used to satisfy a spend-down. However, rates established by the department for long-term care in nursing homes and residential care facilities for the mentally retarded and physically handicapped must be used to calculate the continuing monthly spend-down for a recipient who resides in a long-term care facility during the period between the date of application and the determination of eligibility.

A. The spend-down requirement must be met on a monthly basis by a person residing in a long-term care facility, a person with a personal care assistant, a person receiving health services under parts 9505.2250 to 9505.2380, and a person approved by the department because the person's costs for medically necessary health services regularly exceed the spend-down and the person will not be provided those services without guarantee of eligibility. For purposes of this item, "personal care assistant" means a person who meets the training requirements set by the department to provide personal care service.

B. The monthly spend-down of a person residing in a long-term care facility shall be the net income remaining after deducting subitems (1) to (4). The spend-down must be applied to monthly health service costs in the order incurred until the spend-down is satisfied. For purposes of this item, deductions are:

(1) the clothing and personal needs allowance specified in Minnesota Statutes, section 256B.35;

(2) in the case of a person who is mentally retarded as defined in part 9525.0010, subpart 11 or is certified as disabled as defined in part 9505.0040, items E to H and is employed under a plan of rehabilitation, a special monthly personal allowance of the first $50 of gross monthly earned income;

(3) the amount that, together with the income of the spouse and child under age 18 as specified in part 9505.0075, would provide net income equal to the medical assistance standard for the family size of the dependents excluding the person residing in the long-term care facility;

(4) for a period of up to three calendar months, the medical assistance standard for a family size of one if the person was not living together with a spouse or child under age 21 at the time the person entered a long-term care facility, if the person has expenses of maintaining a residence in the community, and if a physician certifies that the person is expected to reside in the long-term care facility on a short-term basis and expected to return to independent living;

(5) for the month of discharge from a long-term care facility, the medical assistance standard for the appropriate family size which includes the person discharged from the facility.

C. In determining retroactive eligibility on a spend-down basis for periods before an applicant became eligible for aid to families with dependent children, general assistance, or Minnesota supplemental aid or enters long-term care facility for a period expected to last longer than three months, the agency must base its determination on the actual income for the three-month retroactive period and anticipated income for the remaining months of the annual period in subpart 10. Only bills for health services incurred during the month of application and the three calendar months before the month of application may be used to satisfy the spend-down.

D. In all other cases, the spend-down requirement must be met on a six-month basis. Only bills for health services incurred during the month of application and the three calendar months before the month of application may be used to satisfy the spend-down. The person has the right to choose the beginning month of the six-month eligibility period. The choice is limited to the month of application and the three calendar months before application. A

six-month spend-down requirement is satisfied if the bills for health services equal the difference between one-half of the annual anticipated income and six times the medical assistance monthly income standard for the household size.

E. The order in which bills must be used to meet the spend-down is:

(1) health insurance premiums including medicare premiums not deducted from earned income as in subpart 5, item I;

(2) bills incurred for a health service provided to a legal dependent, bills incurred for a health service provided to a responsible relative whose income is used to determine the eligibility of the recipient, and bills incurred for a health service that is allowed under state law but not reimbursable under the medical assistance program; and

(3) bills incurred for a health service that is reimbursable under the medical assistance program. Bills incurred in this subitem must be deducted in chronological order according to the date of service.

F. The recipient is responsible for payment of the spend-down amount calculated by the local agency. The provider is responsible for collecting the amount of the spend-down. After the local agency has determined a person is eligible on the basis of a spend-down, a nonliable third party payer may pay some or all of the person's spend-down requirement. Examples of nonliable third-party payments used to pay the spend-down of an eligible person are funds provided by the Hill Burton program, Services for Children with Handicaps, community fund raisers, and nonresponsible relatives.

G. For persons in long-term care facilities, the daily rate set by the department must be added for each day, in chronological order until the total equals the spend-down. Medical assistance shall cover the balance for the month.

Subp. 12. **Income in retroactive determination.** The local agency shall determine retroactive eligibility on the basis of the applicant's actual net income in the retroactive period.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

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. **Exclusion from third party payer billing requirements.** The department shall exclude from third party payer billing requirements those health services for which the probable existence of liability cannot be determined or for which the third party payer billing is not cost-effective to the department. Providers are not required to bill third party payers for:

A. Prescription drugs and nondurable medical supplies as defined in part 9500.1070, subpart 10, item A, under major medical expense insurance that provides protection against extraordinary medical expenses that would otherwise create a serious financial hardship. This exclusion does not apply to pharmacy only insurance and private health maintenance organization plans (HMOs), Medicare approved charges, and durable medical equipment as defined in part 9500.1070, subpart 10, item B.

B. Early periodic screening diagnosis and treatment (EPSDT) claims except when the person is covered by a private health maintenance organization plan (HMO).

C. Claims for which the submitted charge is less than $5. For purposes of this item, "claim" means a single line on the pharmacy and medical supply invoice of the department and the total of all lines on other invoice forms of the department.

D. Personal care attendant services provided by unlicensed personnel.

E. Day activity center (DAC) services.

F. Waivered services billed to the department by the local agency.

G. Routine physical examinations excluded from payment by a third party payer.

H. Nonassignable insurance claims.

I. Other health services for which the Health Care Financing Administration (HCFA) has granted the state a waiver. The department will implement any waiver approved by HCFA or discontinue any waiver withdrawn by HCFA within 60 days after the department's receipt of the notice from HCFA.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

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. **Cooperation in establishing paternity and obtaining medical support.** Except as provided in subparts 4 and 5, a person must cooperate with the department and local agency in establishing paternity of an eligible child and in obtaining medical care support and payments for himself or herself and any other person for whom he or she can legally assign rights. Cooperation includes providing the local agency or the department with information, appearing at a state or local office to provide information or evidence relevant to the case, appearing as a witness at a court or other proceeding, paying to the local agency or the department any medical support or medical care funds received that are covered in the assignment, providing information or attesting to lack of information under penalty of perjury, and taking other reasonable steps to establish paternity and obtain medical support. A person who fails to cooperate in establishing paternity or obtaining medical support is ineligible for medical assistance. The person who is otherwise eligible for medical assistance shall not have eligibility denied because his or her caretaker refuses to cooperate.

Subp. 4. **Good cause exemption from the requirement to cooperate in establishing paternity or obtaining medical care support for children.** Before requiring an individual to cooperate in establishing paternity or obtaining medical care support for children, 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 a later time. When an individual submits a good cause claim in writing, the local agency must stop action related to obtaining medical care support and payments. The individual shall submit corroborative evidence of good cause claim to the local agency within 20 days of submitting the claim.

A. Good cause exists when:

(1) a child for whom medical support is sought was conceived as the result of incest or rape;

(2) legal proceedings for the adoption of a dependent child are pending before a court of competent jurisdiction; or

(3) the person is receiving services from a licensed adoption agency to determine whether to keep the child or relinquish the child for adoption, and the services have not been provided for longer than three months.

B. Good cause exists when the individual documents that his or her cooperation would not be in the best interest of the dependent child because the cooperation could result in:

(1) physical harm to the child;

(2) emotional impairment of the child that would substantially affect the child's functioning; or

(3) physical harm to or emotional impairment of the individual that would substantially affect the individual's functioning and reduce the individual's ability to adequately care for the child.

C. 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 requires additional evidence to make a determination on the claim for good cause, the local agency 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.

D. A local agency shall determine whether good cause exists based on the weight of the evidence.

E. When a local agency determines that a good cause exists, the exemption from cooperation under subpart 3 must remain in effect for the period the child remains eligible under that application, except for subitems (1) to (4).

(1) A good cause exemption allowed because a child was conceived as the result of incest or rape must continue until a later acknowledgment of paternity or an application for adoption by a second parent is submitted for that child.

(2) A good cause exemption allowed because of adoption proceedings must be issued for a fixed period based on the expected time required to complete adoption proceedings. The exemption must be extended when the required time is longer than was anticipated and must stop when adoption proceedings are discontinued or completed.

(3) A good cause exemption allowed because of adoption counseling must last no more than three months from the time the counseling began.

(4) A good cause exemption must be allowed under later applications without additional evidence when the factors that led to the exemption continue to exist. A good cause exemption allowed under item B must end when the factors that led to allowing the exemption have changed.

F. A good cause exemption that has been allowed by a local agency for a person must be honored by the local agency in the county of residence when the person moves into that county, until the factors that led to allowing the exemption change.

G. When a local agency denies a claim for a good cause exemption and resumes its enforcement action, the local agency shall require the individual to submit additional evidence in support of a later claim for a good cause exemption before the local agency can again stop action to enforce medical support under subpart 3.

H. Following a determination that a person has good cause for refusing to cooperate, a local agency shall take no further action to enforce medical support until the good cause exemption ends according to item E.

Subp. 5. **Good cause exemption from the requirement to cooperate in obtaining medical care support or payments for other persons.** 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 subd 2*

History: *11 SR 1069*

9505.0075 RESPONSIBILITY OF RELATIVES.

Subpart 1. **General requirements; financial obligation of responsible relative.** A responsible relative has an obligation to contribute partial or complete repayment of medical assistance given to a recipient for whom he or she is responsible. The financial obligation of a responsible spouse must be determined under subpart 3 and the financial obligation of a parent must be determined under subpart 6 if the responsible spouse or parent provides the information needed to make the determination. The responsible spouse or parent who refuses to provide information needed to determine the financial obligation under subparts 3 and 6 is obligated to reimburse the local agency for the full amount of medical assistance paid for health services provided to the recipient. The local agency may reduce the amount to be paid on the financial obligation determined under subpart 3 or 6 if payment of the financial obligation will cause the responsible relative undue hardship. In no case shall the financial obligation determined under subpart 3 or 6 for the responsible spouse or parent exceed the amount of medical assistance ultimately provided the recipient.

Subp. 2. **Consideration of spouses' assets and income.** The assets and income of spouses living together must be considered available to each spouse in determining medical assistance eligibility for either or both spouses. When spouses do

not live together, the presumption of availability of spousal assets and income ends on the first day of the month following the month in which the spouses cease living together.

Subp. 3. **Financial obligation when spouses do not live together.** If spouses do not live together during a period of medical assistance eligibility, the financial obligation of the responsible spouse to reimburse the medical assistance program for costs of services provided to the recipient must be determined according to items A to F:

A. A responsible spouse who is a recipient of medical assistance, aid to families with dependent children, general assistance, general assistance medical care, Minnesota supplemental aid, or supplemental security income has no obligation to contribute income or assets.

B. At the time of the first approved application for medical assistance is approved, the local agency shall determine the available assets of the responsible spouse who is not an applicant or recipient. The following assets must be excluded from the determination:

(1) liquid assets up to $10,000 regardless of family size; and

(2) all other assets allowed as exclusions in part 9505.0060 other than assets in subpart 4, item A.

The responsible spouse may reduce assets in excess of subitems (1) and (2) as in part 9505.0063, subpart 1 between the date of application and the date of determination of eligibility or 45 days after the date of application, whichever is later. The responsible spouse shall pay the medical assistance program one-third of the remaining excess assets. The one-third of the excess may be paid as a lump sum or in 12 equal monthly installments together with any monthly obligation determined under items C, D, and E or with the agreement of the county and the responsible relative, in less than 12 equal monthly payments. The responsible relative who chooses to pay the excess as a lump sum shall pay the excess within 30 days of the date of the notice from the local agency under subpart 8. A responsible relative who chooses monthly payments shall make the first payment as specified in the notice in subpart 8. If the sum of the monthly obligation under items C, D, and E and the amount of the excess asset resulting from the division into 12 monthly installments exceeds the monthly cost of the health service, the local agency shall reduce the payment from excess assets so that the sum is equal to the monthly cost of the health service. Payment in this manner shall continue until the obligation to contribute from assets is satisfied.

C. Within 30 days of an approved application for medical assistance, the local agency shall determine the responsible spouse's income liability. The local agency shall redetermine the income liability of a responsible spouse annually or more frequently when a change is known to the agency. However, a responsible spouse shall not be required to report income more often than annually. In determining the responsible spouse's net income, the local agency shall permit the income deductions provided in part 9505.0065. Valuation of spousal assets must include transferred assets on the same basis as specified in part 9505.0064.

D. The local agency shall determine the monthly payment to be made by the responsible spouse from the following payment scale:

Responsible Spouse's Net Monthly Income	Responsible Spouse's Monthly Payment
$ 0 - 639	$0
640 - 748	30 percent of the amount over $640
749 - 959	$32 plus 40 percent of the amount over $749
960 - 1,124	$116 plus 50 percent of the amount over $960

1,125 - and over	$198 plus 100 percent of the amount over $1,125

The department shall adjust the scale by the percentage and at the time of cost of living increases in the Retirement, Survivors, and Disability Insurance.

E. The local agency shall reduce the responsible spouse's monthly payment by the child standard in part 9500.0190 for the number of children living together with the responsible spouse as specified in this part.

F. The responsible spouse shall pay the amount determined under item D. The payments shall be made:

(1) monthly if the amount of medical assistance to be paid for health services to the recipient is known; or

(2) in a lump sum on an annual basis at the end of a calendar year if the amount to be paid is unknown or if the responsible spouse's income is received on an annual basis.

Subp. 4. **Financial obligation of responsible spouse or parent of state hospital resident.** The financial obligation of a responsible spouse or parent of a state hospital resident must be determined and enforced by the state hospital reimbursement office according to Minnesota Statutes, sections 246.51 and 246.511 and parts 9515.1000 to 9515.2600.

Subp. 5. **Consideration of parental income.** The income of a parent must be considered available in determining a child's eligibility for medical assistance as provided in items A to G. For purposes of this subpart, the status of parent ends when a child marries, or when a court of law terminates parental rights.

A. If the child is under age 21 and lives together with the parent, a parent's income and assets must be considered available in determining the child's eligibility.

B. If the child is under 18 and not living together with either parent, the child's eligibility must be based on the child's income and assets. The parent's income must be considered only in regard to a financial obligation to contribute under subpart 6.

C. If the child is under age 18 and living with one parent, the child's eligibility must be based on the child's income and assets and the income and assets of the parent living with the child. The parent not living with the child is obligated to contribute under subpart 6.

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

E. If the child is age 18 or older, is not living together with the parent, and is not claimed as a tax dependent while attending a high school, college, university, postsecondary area vocational technical institute, or a private business, trade, vocational or technical school accredited, licensed, or approved under state laws and rules, the parent has no financial obligation.

F. If a child is a recipient of supplemental security income, parental income and assets must not be considered even if the child lives together with the parent.

G. If a child is under 18 and living together with the parents and the child's eligibility for medical assistance was determined without consideration of the parent's income and assets as part of a home- and community-based waiver under Minnesota Statutes, sections 256B.49 and 256B.491, the parent's income must be considered in regard to an obligation under subpart 6, item D.

Subp. 6. **Parental financial obligation.** When the parent has a financial obligation under subpart 5, item B, the parent's financial obligation to reimburse the medical assistance program for the costs of services provided by medical assistance to the child recipient must be determined according to items A to F. A parent who makes child support payments as ordered by the court shall have the amount paid subtracted from any obligation determined under this part.

A. A parent has no obligation to contribute assets.

B. The payments of a parent who has an obligation to pay must be determined according to parts 9550.6200 to 9550.6240.

C. A parent who has more than one child living apart from him or her is not required to pay more than the amount for one child. In this case, the parent shall pay the lesser of five percent of the parent's income or the amount determined under item B for the child with the highest expenditures for health services eligible for medical assistance payment.

D. In determining parental payments for the cost of health services provided a child under a medical assistance home- and community-based waiver while living together with the parent, the local agency shall subtract the room and board amount established in part 9505.0065, subpart 9, item A, from the parent's obligation.

E. A parent who adopts a child under the subsidized adoption program as in part 9505.0055, subpart 4 shall have no additional financial obligation under parts 9505.0010 to 9505.0150.

F. A parent who refuses to provide information needed to determine the parent's financial obligation is obligated to reimburse the local agency for the full amount of medical assistance paid for health services provided to the child.

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

Subp. 8. **Notice to responsible spouse or parent.** When making an initial determination of eligibility, the local agency shall give written notice to the responsible spouse or parent within 30 days of the date of notice of the person's eligibility. Further, the local agency shall notify the responsible spouse or parent 30 days prior to the effective date of an increase in the obligation to be paid by the responsible spouse or parent. A decrease in the obligation to be paid by the responsible spouse or parent is effective the month following the month of the change in the cost of care or the responsible parent's or spouse's income or household size. The notice shall state the amount of the obligation to be paid, to whom the payment shall be made, the time a payment is due, penalties for refusing or failing to pay, and the right to appeal.

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

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

Unless the responsible spouse's or parent's income and assets are deemed available to the applicant or recipient, the refusal or failure of a responsible

spouse or parent to pay the obligated amount does not affect the recipient's medical assistance eligibility. If the medical assistance payment to the long-term care facility has been reduced by the expected amount of the responsible spouse's or parent's obligation and the relative fails to pay within 60 days, the local agency shall adjust the payment to the long-term care facility so that the facility is paid the facility's per diem rate less the recipient's monthly spend-down from the time of the responsible relative's refusal or failure to pay.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

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 subd 2*

History: *11 SR 1069*

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 subd 2*

History: *11 SR 1069*

9505.0090 LOCAL AGENCY ACTION ON APPLICATION.

Subpart 1. **Eligibility determination.** The local agency shall interview the applicant or authorized representative and complete the eligibility determination within the time limit in subpart 2. The local agency shall grant medical assistance to an applicant who satisfies the eligibility factors under parts 9505.0010 to 9505.0150.

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 9505.0150 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 subd 2*

History: *11 SR 1069*

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 subd 2*

History: *11 SR 1069*

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 9505.0150. 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 subd 2*

History: *11 SR 1069*

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 subd 2*

History: *11 SR 1069*

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 as in part 9505.0063, subpart 1. Retroactive eligibility is available on the date after the day on which excess assets are reduced under part 9505.0063, subpart 1. 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. **Other periods of eligibility.** Other periods of eligibility shall be as in items A to D:

A. A person whose income is at or below the maximum in part 9505.0065, subpart 1 is eligible for 12 months if all eligibility factors remain satisfied.

B. A person who is eligible on a monthly spend-down basis is eligible for 12 months if all eligibility factors remain satisfied.

C. A person whose spend-down is calculated under part 9505.0065, subpart 11, item D is eligible for six months.

D. A person retaining medical assistance eligibility after termination of aid to families with dependent children under part 9505.0055, subpart 3, is eligible for medical assistance for the period specified in that subpart.

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; or

B. the starting date is delayed by an income spend-down requirement under part 9505.0065, subpart 11; or

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

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

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. The redetermination must be completed so that the change can go into effect by the second month following the month of the change.

Subp. 3. **Periodic redetermination.** The local agency shall perform periodic redeterminations before the end of the eligibility periods defined in part 9505.0110, subpart 2, items A and B, so that eligibility is not interrupted because of agency delay of redetermination. The local agency shall review quarterly those cases where the person's assets are within $300 of the asset limitations in parts 9505.0059 and 9505.0060.

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. **Redetermination after change in recipient category.** The local agency shall review a person's eligibility when the basis for the person's eligibility changes from one of the categories listed in part 9505.0040 to another category listed in part 9505.0040. If the basis for eligibility changes from one of the categories listed in parts 9505.0016 and 9505.0055, subparts 1 to 5 to one of the categories listed in part 9505.0040, the local agency shall require the person to make a new application if the person wants medical assistance. The local agency shall require the person to provide the information necessary to complete the agency's review. However, the local agency shall assist the person who is shifting categories to minimize any disruption in eligibility by promptly notifying the person of any requirements to be met and any deadlines that could affect continued receipt of medical assistance.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

9505.0120 REAPPLICATION.

A new application is required if a person's previous application has been denied or withdrawn, if a previous six-month spend-down period has expired, or if the person wants a determination of only medical assistance eligibility after loss of concurrent eligibility for receipt of public assistance under part 9505.0055.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

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 depart-

ment, 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 9505.0150. 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 subd 2*

History: *11 SR 1069*

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. **Right to apply pending decision on aid to families with dependent children appeal.** When a termination of the aid to families with dependent children grant has been appealed by the assistance unit and benefits to the assistance unit are continuing from the aid to families with dependent children grant and medical assistance program pursuant to that appeal, the local agency shall notify the recipients of their right to immediately file a request for medical assistance. The local agency shall place these requests in a pending status until the outcome of the appeal is known. If the appeal is denied, the local agency shall determine the person's eligibility for medical assistance.

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 subd 2*

History: *11 SR 1069*

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 subd 2*

History: *11 SR 1069*

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 9505.0150. 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. **Responsibility for payments.** The county of service is solely and fully responsible for a payment made on behalf of a recipient when the payment results from:

A. Late or inaccurate eligibility redetermination according to part 9505.0115. Federal and state shares of the costs of health services for persons whose eligibility redetermination is overdue by more than 60 days are the responsibility of the county of service beginning with the end of the second month of overdue status. The servicing county may complete the eligibility redetermination and appeal the decision before 120 days. The local agency will remain responsible for the costs if the late redetermination results in the eligibility of an otherwise ineligible individual. Federal and state shares of costs incurred for persons whose eligibility redeterminations are at least 120 days overdue are the responsibility of the county of service, regardless of the individual's eligibility status starting with the end of the second month of overdue status. A local agency may not challenge a penalty arising from a redetermination that is overdue for 120 days or more.

B. Noncompliance with utilization control requirements in parts 9505.1750 to 9505.2150.

C. Inaccuracy or incompleteness of records that are required by subpart 3.

D. Failure to submit to the department accurate and timely information

about the closing of cases. For purposes of this item, "timely" means that a local agency issuing a termination notice under part 9505.0125 notifies the department of the termination in sufficient time so that the department will not issue the person a medical assistance identification card or continue the person's eligibility for a prepaid capitation rate to a health plan for the month after the month in which the local agency issued the termination notice.

Subp. 6. **Responsibility for errors.** If an original county of service transfers responsibility for services to another county, fiscal penalties arising from overdue eligibility redeterminations are the responsibility of the original county for the month of transfer, and for the first 30 days after the date of the transfer.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

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 hearing-impaired person 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.** Within 90 days after the effective date of parts 9505.0010 to 9505.0150 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 subd 2*

History: *11 SR 1069*

9505.0145 IDENTIFICATION CARDS.

Subpart 1. **Issuance by local agency.** The local agency of the county of service shall issue the initial medical assistance identification card together with the notice of eligibility specified in part 9505.0100. The identification card and notice must be issued directly to the medical assistance applicant within five days of establishing the applicant's initial eligibility. The local agency shall record the issuance of the card on forms approved by the department.

Subp. 2. **Issuance by department.** Based upon client eligibility information sent by the local agencies, the department shall issue medical assistance identification cards to eligible recipients or their legal guardians. However, a recipient participating in a health maintenance organization or other prepaid health service plan under contract with the department must be issued an identification card by the health maintenance organization.

Subp. 3. **Use of identification cards.** A provider or vendor of a health service may require a recipient to present a valid identification card, or may certify current eligibility through the local agency, before providing the health service to the recipient. The provider or vendor should verify that the recipient is currently eligible in order to ensure payment for a service eligible for payment under the medical assistance program.

Subp. 4. **Restriction of use of card.** The department may restrict the recipient's use of an identification card to designated providers or vendors of health services to prevent duplication or abuse of health services, to prevent the violation of prior authorization requirements, or to ensure continuity of care. A restriction must comply with parts 9505.1760 to 9505.2150 and is subject to the appeal process under part 9505.0130.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

9505.0150 WARNING STATEMENT IN LANGUAGES OTHER THAN ENGLISH.

The commissioner shall prepare a written statement in English, Spanish, Laotian, Vietnamese, Cambodian, Hmong, and other languages that the commissioner determines appropriate for the applicants and recipients, that states that the written document accompanying the statement is very important, and that if the reader does not understand the document, the reader should seek immediate help. The written statement must accompany all written information given by the department or a local agency to an applicant or recipient.

Statutory Authority: *MS s 256B.04 subd 2*

History: *11 SR 1069*

HOSPITAL ADMISSIONS CERTIFICATION

9505.0500 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9505.0500 to 9505.0540, the following terms have the meanings given them.

Subp. 2. **Admission.** "Admission" means 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 inpatient hospitalization is medically necessary and that medical assistance or general assistance medical care 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 9500.0750 to 9500.1080, 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 and who is a party to a written provider agreement with the department.

Subp. 5. **Certification number.** "Certification number" means the number issued by the medical review agent.

Subp. 6. **Clinical evaluator.** "Clinical evaluator" means a person who is employed by or under contract with the medical review agent and who is either licensed by the Minnesota Board of Nursing to practice professional nursing under Minnesota Statutes, section 148.171, or a physician.

Subp. 7. **Commissioner.** "Commissioner" means the commissioner of human services or an authorized representative of the commissioner.

Subp. 8. **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. 9. **Continued stay review.** "Continued stay review" means a review and determination, after the admission certification and during a patient's hospitalization, of the medical necessity of continuing the recipient's stay at a hospital level of care.

Subp. 10. **Department.** "Department" means the Minnesota Department of Human Services.

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

Subp. 12. **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, section 256D.03, and applicable rules adopted by the commissioner as either may from time to time be amended and enforced.

Subp. 13. **Hospital.** "Hospital" means an institution that is approved to participate as a hospital under Medicare and that is maintained primarily for the treatment and care of patients with disorders other than mental diseases and tuberculosis.

Subp. 14. **Inpatient hospital service.** "Inpatient hospital service" means a service provided under the supervision of a physician and furnished in a hospital for the care and treatment of a recipient. The inpatient hospital service may be furnished by a hospital, physician, or a vendor of an ancillary service prescribed by a physician that may be paid for under medical assistance or general assistance medical care.

Subp. 15. **Local agency.** "Local agency" means a county or multicounty agency authorized under Minnesota statutes as the agency responsible for determining eligibility for the medical assistance and general assistance medical care programs.

Subp. 16. **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. 17. **Medical record.** "Medical record" means the information required in part 9505.1800, subpart 3.

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

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 9505.0540 cannot be provided on an outpatient basis.

Subp. 20. **Medicare.** "Medicare" means the federal health insurance program for the aged and disabled under title XVIII of the Social Security Act.

Subp. 21. **Physician.** "Physician" means a person licensed to provide services within the scope of the profession as defined in Minnesota Statutes, chapter 147.

Subp. 22. **Physician adviser.** "Physician adviser" means a physician who practices in the specialty area of the recipient's primary diagnosis or a specialty area related to the primary diagnosis.

Subp. 23. **Prior authorization.** "Prior authorization" means the prior approval for medical services by the department as required under applicable rules and regulations adopted by the commissioner.

Subp. 24. **Readmission.** "Readmission" means an admission that occurs within seven days of a discharge of the same recipient.

Subp. 25. **Recipient.** "Recipient" means a person who has applied to the local agency and has been determined eligible for the medical assistance or general assistance medical care program.

Subp. 26. **Reconsideration.** "Reconsideration" means a review of a denial or withdrawal of admission certification according to part 9505.0520, subpart 9.

Subp. 27. **Retrospective review.** "Retrospective review" means a review conducted after inpatient hospital services are provided to a recipient. The review is focused on 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.

Statutory Authority: *MS s 256B.04 subd 15; 256B.503; 256D.03 subd 7*

History: *9 SR 2296; 11 SR 1687*

9505.0510 APPLICABILITY.

Parts 9505.0500 to 9505.0540 establish the standards and procedures for admission certification to be followed by admitting physicians and hospitals seeking medical assistance or general assistance medical care payment for inpatient hospital services provided to medical assistance or general assistance medical care recipients under Minnesota Statutes, chapters 256B and 256D. Parts 9505.0500 to 9505.0540 are to be read in conjunction with Code of Federal Regulations, title 42, and titles XVIII and XIX of the Social Security Act. The department retains the authority to approve prior authorizations established under parts 9505.5000 to 9505.5105. Parts 9505.0500 to 9505.0540 do not apply to out-of-state hospitals and admitting physicians who seek medical assistance or general assistance medical care program payment for inpatient hospital services provided to recipients who are Minnesota residents. Instate admitting physicians who admit a Minnesota resident who is a recipient to an out-of-state hospital must comply with parts 9505.0500 to 9505.0540. Out-of-state admitting physicians who admit a Minnesota resident who is a recipient to an in-state hospital must comply with parts 9505.0500 to 9505.0540.

Statutory Authority: *MS s 256B.04 subd 15; 256B.503; 256D.03 subd 7*

History: *9 SR 2296; 11 SR 1687*

9505.0520 INPATIENT ADMISSION CERTIFICATION.

Subpart 1. **Requirement for admission certification.** Except as provided in subparts 2 and 14, an admission providing inpatient hospital service to a recipient must receive admission certification prior to the recipient's admission in order for the admitting physician, the hospital, or other vendor of an inpatient hospital service to receive medical assistance or general assistance medical care program payment for the inpatient hospital service.

Subp. 2. **Exclusions from admission certification or prior admission certification.** Admission for inpatient hospital services under items A and B shall be excluded from the requirement in subpart 1.

A. An emergency admission may occur without prior admission certification and shall be subject to subpart 4, item B.

B. Admission certification is not required for delivery of a newborn, inpatient dental procedures, or inpatient hospital services for which a recipient has been approved under Medicare. However, denial of an inpatient hospital service under Medicare because the service is not medically necessary shall also constitute sufficient grounds for denying payment for the service under medical assistance.

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

A. Obtain prior authorization from the department for any service requiring prior authorization. Medical assistance and general assistance medical care payment shall be denied when a required prior authorization is not obtained prior to admission.

B. Request admission certification by contacting the medical review agent either by phone 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, medical assistance or general assistance medical care identification number, and date of birth;

(3) admitting physician's name and medical assistance provider number;

(4) primary procedure code 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 Commission on Professional and Hospital Activities, Green Road, Ann Arbor, Michigan 48105 which are incorporated by reference. These books are available through the Minitex interlibrary loan system and are subject to change;

(5) expected date of admission;

(6) whether the admission is a readmission;

(7) admitting diagnosis by diagnostic code 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 medically necessary.

C. Provide the following information when applicable:

(1) surgeon's name and medical assistance provider number;

(2) expected date of surgery; and

(3) affirmation that a second surgical opinion and prior authorization have been received.

D. Inform the hospital of the certification number.

E. For purposes of billing, enter the certification number on, and attach a copy of a necessary prior authorization form and a second or third surgical opinion to all invoices submitted to the department for payment.

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

A. Obtain the certification number from the admitting physician or, for an admission for chemical dependency treatment, from the person who conduct-

ed the assessment of the recipient for chemical dependency treatment as specified in parts 9530.6600 to 9530.6655.

B. In an emergency admission, inform, by phone, the medical review agent of the emergency admission and provide the information required in subpart 3, items B and C, if applicable, within 48 hours of the emergency admission exclusive of weekends and holidays. If the hospital fails to notify the medical review agent within 48 hours excluding weekends and holidays, the hospital shall submit, at its own expense, a copy of the complete medical record to the medical review agent within 30 days after the recipient's discharge. Failure to submit the record within the 30 days shall result in denial of the certification number.

C. For billing purposes, enter the certification number on all invoices submitted to the department for payment.

Subp. 5. **Retroactive eligibility.** A hospital may seek admission certification for a person found retroactively eligible for medical assistance or general assistance medical care program benefits after the date of admission. The hospital shall inform the admitting physician of the admission certification number of a retroactively eligible recipient. An admitting physician and a hospital shall not seek admission certification for a person whose application for the medical assistance or general assistance medical care program is pending. The medical review agent may require the hospital to submit, at its own expense, a copy of the complete medical record to substantiate the medical necessity of the admission. Failure to submit a requested record within 30 days of the request shall result in denial of admission certification.

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

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

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

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

D. mail a written notice of the admission certification determination to the admitting physician and the hospital within five days of the determination, exclusive of weekends and holidays;

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

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

G. recruit and coordinate the work of the physician advisers;

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

I. mail a written notice of the reconsideration decision to the admitting physician, the person responsible for the hospital's utilization review, and the department within ten days of the determination, exclusive of weekends and holidays;

J. provide for consideration of a request for retroactive admission certification; and

K. issue a certification number for a recipient whose condition requires chemical dependency treatment in a hospital as indicated in an assessment made according to parts 9530.6600 to 9530.6655.

Subp. 7. **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

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; or

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 procedure for admission certification shall be as in items A to H.

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

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

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

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

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

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

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

H. If the second physician adviser is unable to determine that the admission is medically necessary, the medical review agent shall deny the admission certification and shall not issue a certification number.

Subp. 9. **Reconsideration.** The admitting physician or the hospital may request reconsideration of a decision to deny or withdraw an admission certification. The admitting physician or the hospital shall submit the request in writing to the medical review agent within 30 days of the date of receipt of the letter denying or withdrawing admission certification. Upon receipt of the request, the medical review agent shall appoint at least three physician advisers, none of whom shall have been involved previously in the procedure for the recipient's admission certification, to hear the reconsideration. The reconsideration may be conducted by means of a telephone conference call. The admitting physician or the hospital may submit additional facts at their own expense to support the request for admission certification. The physician advisers may seek additional facts and medical advice as necessary to decide whether the admission is medically necessary. The reconsideration shall be completed within 30 days of the receipt of the request. The admitting physician or the hospital may appeal the determination of the physician advisers according to the contested case provisions of Minnesota Statutes, chapter 14, by filing a written notice of appeal with the commissioner within 20 days of the date of receipt of the notice of the determination.

Subp. 10. **Medical record review and determination.** The medical review agent shall be authorized to conduct a concurrent, continued stay, or retrospective review of a recipient's medical record to determine whether the admission was medically necessary, whether the inpatient hospital services were medically

necessary, whether a continued stay will be medically necessary, or whether all medically necessary services were provided. The procedure for concurrent, continued stay, and retrospective reviews shall be as in items A to D.

A. A clinical evaluator shall review the medical record and may review the bills, invoices, and all supporting documentation pertaining to a request for medical assistance and general assistance medical care payment.

B. If the clinical evaluator is unable to determine that the recipient's admission was medically necessary, that the recipient's continued stay will be medically necessary, or that all medically necessary services were provided, the clinical evaluator shall request additional information from the admitting physician or the hospital as necessary to clarify the medical record.

C. If, after additional information is submitted, the clinical evaluator is unable to determine that the recipient's admission was medically necessary, that the recipient's continued stay will be medically necessary, or that all medically necessary services were provided, a physician adviser shall be consulted.

D. If a physician adviser determines that the recipient's admission was not medically necessary, that the recipient's continued stay will not be medically necessary, or that all medically necessary services were not provided, the medical review agent shall withdraw the previously issued certification number and shall notify the admitting physician and hospital by telephone within 24 hours of the determination and by written notice mailed within 24 hours.

Subp. 11. **Consequences of withdrawal of admission certification.** If the medical review agent determines that the admission was not medically necessary or that all medically necessary inpatient hospital services were not provided or that some or all of the inpatient hospital services were not medically necessary, the department shall withdraw the certification number and may take action as specified in items A to E.

A. For hospitals receiving payments on a per admission basis, the entire payment shall be debited for an admission that was not medically necessary. If the admission was medically necessary but some or all of the inpatient hospital services were not medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150. If the hospital failed to provide services that were medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150.

B. For hospitals receiving per diem payment, no payment shall be made if the admission was not medically necessary. If the stay or a portion of the stay was not medically necessary, no payment shall be made for the portion of the stay that was not medically necessary.

C. If the medical review agent determines that additional inpatient hospital services will not be medically necessary, the medical review agent shall notify the hospital, admitting physician, and the recipient or the person designated by the recipient in the hospital record that no payment will be made for additional hospital services.

D. If the admission was not medically necessary or the medical record does not adequately document that the admission was medically necessary, the department may seek to recover payments made to physicians and other vendors of inpatient hospital services under parts 9505.1750 to 9505.2150.

E. If an inpatient hospital service is not medically necessary, payment for a service not medically necessary shall be denied to the vendor of the service except as provided in items A and B.

Subp. 12. **Appeal of withdrawal of admission certification.** The withdrawal of admission certification may be appealed to the medical review agent through the reconsideration process in subpart 9.

Subp. 13. **Information used for determination.** At any stage of the admission

certification process, including reconsideration, the person or persons making the determination may do so on the information provided by the admitting physician, or in their sole discretion may refer to additional facts submitted by the admitting physician.

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

Statutory Authority: *MS s 256B.04 subd 15; 256B.503; 256D.03 subd 7*

History: *9 SR 2296; 11 SR 1687*

9505.0530 INCORPORATION BY REFERENCE OF CRITERIA TO DETERMINE MEDICAL NECESSITY.

The most recent edition of the Appropriateness Evaluation Protocol of the National Institutes of Health is incorporated by reference. The book is available at the Health Data Institute, 7 Wells Avenue, Newton, Massachusetts, 02159, and it is also available through the Minitex interlibrary loan system. The book is subject to change.

The Criteria for Inpatient Psychiatric Treatment, 1981 edition, 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, Ford Building, Saint Paul, Minnesota 55155. The criteria are not subject to frequent change.

Statutory Authority: *MS s 256B.04 subd 15; 256B.503; 256D.03 subd 7*

History: *9 SR 2296; 11 SR 1687*

9505.0540 CRITERIA TO DETERMINE MEDICAL NECESSITY.

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

Subp. 2. **Determination for admission for chemical dependency treatment.** The assessment of a recipient's need for chemical dependency treatment in a hospital shall be made according to parts 9530.6600 to 9530.6655. The person who conducted the assessment shall contact the medical review agent and request a certification number. If the person who conducted the assessment reports that the recipient meets the criteria for chemical dependency treatment in a hospital, the medical review agent shall issue a certification number.

Statutory Authority: *MS s 256B.04 subd 15; 256B.503; 256D.03 subd 7*

History: *9 SR 2296; 11 SR 1687*

GENERAL ASSISTANCE MEDICAL CARE

9505.1000 STATUTORY AUTHORITY FOR GENERAL ASSISTANCE MEDICAL CARE PROGRAM.

This rule establishes a statewide general assistance medical care program and governs state financial participation in county welfare medical costs as authorized by Laws of Minnesota 1975, chapter 437, article II.

Statutory Authority: *MS s 256D.03 subds 3,4,5*

9505.1010 PURPOSE OF RULES.

The purposes of parts 9505.1010 to 9505.1040 are to provide medical services to persons financially unable to provide it for themselves, and whose medical needs are not otherwise provided for by law; and to provide property tax relief by providing state financing for some medical costs historically financed by county property tax levies.

Statutory Authority: *MS s 256D.03 subds 3,4,5*

9505.1020 DEFINITIONS.

Subpart 1. **Scope.** The terms defined in this part shall have the meanings given them unless otherwise provided or indicated by the context.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of human services or his/her designee.

Subp. 3. **Department.** "Department" means the Department of Human Services.

Subp. 4. **General assistance medical care.** "General assistance medical care" means payment of part or all of the cost of the following care and services not provided by titles XVIII, XIX, or XX of the Social Security Act for eligible individuals whose income and resources are insufficient to meet all such costs:

A. inpatient hospital services;

B. skilled nursing home and intermediate care facility services;

C. physician's services;

D. outpatient hospital or clinic services;

E. home health care services;

F. private duty nursing service;

G. physical therapy and related services;

H. dental services;

I. laboratory and X-ray services;

J. the following, if prescribed by a licensed practitioner: drugs, eyeglasses, dentures, and prosthetic devices;

K. diagnostic, screening, and preventive services;

L. transportation costs incurred solely for obtaining medical care; and

M. any other medical or remedial care licensed and recognized under state law to the extent that such services are provided for in the medical assistance program.

To be excluded from the services above are the following:

N. jejuno-ileal bypass surgery;

O. cosmetic surgery;

P. contact lenses unless prescribed for Kerotoconus or where functional vision is impossible to achieve by other means;

Q. orthodontia unless prior authorization has been obtained from the local agency subject to review by the state dental advisory committee;

R. psychiatric and psychological services unless the need for them has been preauthorized by the local agency in accordance with the conditions and limitations prevailing in the medical assistance program;

S. autopsies; and

T. air conditioners, humidifiers, dehumidifiers, and orthopedic mattresses even though they may have some health treatment values.

Subp. 5. **Income.** "Income" means earned and unearned income from any source whatsoever, (including windfalls, income tax refunds, and rebates) reduced by amounts paid or withheld for federal and state income taxes, federal social security taxes, and employment expenses. The local agency may adopt a standardized allowance schedule for usual employment expenses.

Subp. 6. **Local agency.** "Local agency" means the county welfare boards in the several counties of the state except that it may also include any multicounty welfare boards of departments where those have been established in accordance with law.

Subp. 7. **Provider of medical care.** "Provider of medical care" means any persons or facility furnishing, within the scope of his or its respective license, any or all of the services or goods recited in subpart 4.

Subp. 8. **Relatives' responsibility.** "Relatives' responsibility" means that the financial responsibility of a relative for an applicant or recipient of general assistance medical care shall not extend beyond the relationship of a spouse, or a parent of an applicant or recipient who is a child under the age of 18 years.

Statutory Authority: *MS s 256D.03 subds 3,4,5*

History: *L 1984 c 654 art 5 s 58*

9505.1030 ELIGIBILITY REQUIREMENTS.

General assistance medical care benefits shall be granted to any person or family who has all of the following qualifications:

A. Who is currently receiving general assistance in accordance with Minnesota Statutes, sections 256D.01 to 256D.22; or

B. Who is not eligible for or receiving medical care through the programs of Aid to Families with Dependent Children, or emergency assistance-AFDC, or medical assistance, or cost-of-care for mentally retarded, epileptic, or emotionally handicapped children, or state reimbursement for state wards per Minnesota Statutes, section 260.38, or social services under title XX of the Social Security Act, but who otherwise meets eligibility requirements for this general assistance medical care program; and

C. Whose net equity in real and personal property does not exceed the maximum standards established in the medical assistance program according to Minnesota Statutes, sections 256B.06 and 256B.07; and

D. Who does not own or have an equivalent to ownership of more than one family automobile; and

E. Who has not transferred property without receiving reasonable consideration for the purpose of qualifying for general assistance medical care; and

F. Who has or anticipates receiving an annual income not in excess of $2,600 for a single person, or $3,264 for two family members (husband and wife, parent and child, or two siblings), or $3,960 for three family members, or $4,620 for four family members, or $5,184 for five family members, plus $625 for each additional legal dependent, or who has income in excess of these maxima and in the month of application (or during the three months prior to the month of application) incurs expenses for medical care that total more than one-half of the annual excess income in accordance with the rules of the department. In such excess income cases, eligibility shall be limited to a period of six months beginning with the first of the month in which these medical obligations are first incurred; and

G. Who has or agrees to apply all proceeds received or receivable by him or his spouse from private health care coverage or the Minnesota no-fault auto

insurance law to the costs of medical care for himself, his spouse, and legal dependents. The local agency or the department may require from any applicant or recipient of general assistance medical care the assignment of any rights accruing under such health and accident care coverage. Any rights or amounts so assigned shall be applied against the cost of medical care paid for by the general assistance medical care program.

Statutory Authority: *MS s 256D.03 subds 3,4,5*

9505.1040 APPLICATION FOR GENERAL ASSISTANCE MEDICAL CARE.

Subpart 1. **Forms and determinations.** Applications for general assistance medical care shall be reduced to writing on forms prescribed by the department and be filed with the local agency of the county wherein the applicant is residing. The determination of the county of financial responsibility shall be made in accordance with Minnesota Statutes, section 256D.18 and the procedures prescribed therein for referral of applications to other counties shall be followed.

Subp. 2. **Written notice of agency action.** The local agency shall, within 45 days thereafter, selectively ascertain the facts supporting the application and inform the applicant by written notice of the action taken on his application. Any applicant or recipient aggrieved by any order or determination of the local agency may appeal therefrom to the commissioner in accordance with Minnesota Statutes, section 256.045.

Subp. 3. **Selection of medical providers.** Upon approval of such application for a period of eligibility not to exceed six months, the local agency shall advise the recipient whether he may select the medical providers which are to provide him with the necessary medical services and goods or if the local agency is reserving the right to designate the medical providers for him.

Subp. 4. **Delegation of determination of eligibility.** Upon prior approval from the commissioner, a local agency may delegate its responsibility for determining an applicant's eligibility for benefits of this program to other legally established units of county government.

Subp. 5. **Notice to commissioner regarding medical provider.** Each local agency shall notify the commissioner whether it will: pay the medical providers directly and claim state reimbursement (90 percent) in accordance with procedures established by the commissioner, or require that all medical providers submit their claims to the department's central disbursement center for state payment directly to the providers after which the department will bill the local agency for the county share (ten percent) of the payments thus made.

In selecting this alternative, the local agency also agrees to:

A. accept all reimbursement standards and edits of the system which are applied to title XIX payments;

B. maintain current eligibility records on all recipients of general assistance medical care on the title XIX recipient subsystem through the use of form DPW-106; and

C. reimburse 50 percent of the department's costs of processing these medical provider claims.

Subp. 6. **Payments for noneligible persons.** Any local agency may, from its own resources, make payments for medical care for persons not otherwise eligible for this general assistance medical care program.

Subp. 7. **Administration of program.** The local agencies shall administer the general assistance medical program in their respective counties under the supervision of the department, and shall make such reports, prepare such statistics, and keep such records and accounts as the commissioner may require.

Subp. 8. **Limit to payment amounts.** The local agency shall not allow payment of medical provider claims which exceed the fee schedules established by the commissioner for the medical assistance program.

Statutory Authority: *MS s 256D.03 subds 3,4,5*

CATASTROPHIC HEALTH EXPENSE PROTECTION

9505.1100 SCOPE AND STATUTORY AUTHORITY FOR CHEPP.

Parts 9505.1100 to 9505.1380 govern administration of the catastrophic health expense protection program (CHEPP, CHEP program) in Minnesota. It is issued pursuant to Minnesota Statutes, section 62E.54, subdivision 1. They provide the basis for implementation of Minnesota Statutes, sections 62E.51 to 62E.55.

Statutory Authority: *MS s 62E.54 subd 1*

9505.1110 PERSONS REGULATED.

Parts 9505.1100 to 9505.1380 are binding on the Department of Human Services, on all county welfare and human services boards (hereinafter called local welfare agencies), on all persons and organizations contracting to perform functions under the CHEPP act, on providers of health services who are paid or who request payment under the act, and on people who apply for or receive benefits under the act.

Statutory Authority: *MS s 62E.54 subd 1*

History: *L 1984 c 654 art 5 s 58*

9505.1120 UNIFORM IMPLEMENTATION.

The commissioner of human services shall issue handbooks and informational materials to local welfare agencies, to persons and organizations that contract to perform functions required under the CHEPP act, to providers of health services which may be paid for under the act, and to people who apply for or receive benefits under the act, so that the act and parts 9505.1100 to 9505.1380 are put into effect in an orderly and uniform way.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1130 CIVIL RIGHTS PROTECTIONS.

The CHEP program shall be administered so as not to deny people who apply for or receive benefits their individual and civil rights. The program shall give due regard to the rights of its beneficiaries as to privacy of their personal medical records. No disclosure shall be made of such records or of personally identifiable data from them except as permitted by law and then only such pertinent data as is clearly required for proper administration of the program by those persons and organizations responsible for it.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1140 SUBORDINATION OF RULES TO STATE AND FEDERAL LAWS.

Any provision of these parts which is inconsistent with any state or federal law applicable to the CHEP program is superseded thereby.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1150 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 9505.1100 to 9505.1380, the terms defined in this part have the meanings given them.

Subp. 2. **Adjustment.** "Adjustment" means a payment by or to the state of Minnesota intended to change the net amount of an earlier payment made by the CHEP program.

Subp. 3. **Applicant.** "Applicant" means a person who has directly, or through his attorney, guardian, or personally designated representative, made application for benefits from the CHEP program with his local welfare agency. Additionally, an applicant may be a deceased person's estate, on behalf of which an application

is filed by the personal representative of the estate, subject to the restrictions in part 9505.1160, subpart 2.

Subp. 4. **CHEPP beneficiary.** "CHEPP beneficiary" means an eligible or formerly eligible person or his dependent, someone on whose behalf CHEPP benefits have been or may be paid.

Subp. 5. **CHEPP deductible.** "CHEPP deductible" means the sum of qualified expenses which an applicant must have incurred an obligation to pay in order to become an eligible person, as defined in subpart 11.

Subp. 6. **Catastrophic health expense protection program coverage 1 (CHEPP 1).** "Catastrophic health expense protection program coverage 1 (CHEPP 1)" means the set of CHEPP benefits available to persons who have become eligible under the provisions of subpart 11, item A. This coverage is the regular and broad coverage of the CHEP program. It makes no restrictions on benefits on account of age, except as regards defining who may be included in a single family group.

Subp. 7. **Catastrophic health expense protection program coverage 2 (CHEPP 2).** "Catastrophic health expense protection program coverage 2 (CHEPP 2)" means the coverage of some part of the routine per diem costs of nursing home care for persons less than 65 years of age who have become eligible under the provisions of subpart 11, item B.

Subp. 8. **Commissioner.** "Commissioner" means the commissioner of human services, or, as applicable, the commissioner's designated agent in the Department of Human Services, a local welfare agency, or a person or organization contracting to perform functions required for administration of the CHEP program.

Subp. 9. **Copayment.** "Copayment" means the ten percent share of a reasonable charge or qualified expense, in excess of a CHEPP deductible, for which an eligible person remains liable to a provider of health services after payment of the 90 percent share by the commissioner under the provisions of the CHEPP act and parts 9505.1100 to 9505.1380.

Subp. 10. **Dependent.** "Dependent" means a spouse, unmarried child under the age of 19 years, a child who is a student under the age of 25 and financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent, provided such spouse or child is not currently eligible for benefits under the medical assistance program or the general assistance medical care program. The term "child" as used here includes legally adopted children, and it also includes financially dependent stepchildren, foster children, and children under the guardianship of the applicant or his spouse. Eligibility for benefits of children reaching age 19 or 25 shall end on the last day of the birthdate month, in the eligibility year.

Subp. 11. **Eligible person.** "Eligible person" means any person who is a resident of Minnesota and who, while a resident of Minnesota, has been found by the commissioner to have incurred an obligation to pay:

A. qualified expenses for himself and any dependents in any 12 consecutive months exceeding:

(1) 40 percent of his household income up to $15,000, plus 50 percent of his household income between $15,000 and $25,000, plus 60 percent of his household income in excess of $25,000; or

(2) $2,500, whichever is greater; or

B. qualified nursing home expenses for himself and any dependents in any 12 consecutive months exceeding 20 percent of his household income.

Where clearly indicated by the context, "eligible person" shall also mean the dependents of an eligible person as defined in subpart 10.

Subp. 12. **General assistance medical care (GAMC).** "General assistance medical care (GAMC)" means that program of medical assistance for the poor and needy established by Minnesota Statutes, chapter 256D.

Subp. 13. **Gross income.** "Gross income" means income as defined in Minnesota Statutes, section 290A.03, subdivision 3. Cash benefits paid to eligible persons in lieu of payments to providers of health services shall not be included in gross income as defined here, but payments made by the United States Veterans' Administration for "aid and attendance" shall be considered to be a part of gross income rather than medical benefits.

Subp. 14. **Health maintenance organization (HMO).** "Health maintenance organization (HMO)" means an organization offering prepaid health services, as defined in Minnesota Statutes, chapter 62D.

Subp. 15. **Home health agency.** "Home health agency" means a public or private agency which specializes in giving nursing and other therapeutic and rehabilitative services in patients' homes and which is eligible for enrollment as such in the Minnesota medical assistance program.

Subp. 16. **Hospital services.** "Hospital services" means any and all reasonable and medically appropriate services provided on an inpatient or outpatient basis on the direction of a physician or under his supervision by a hospital which meets the requirements for reimbursement as such by the medical assistance program. Hospital services do not include outpatient mental or dental health services, drugs dispensed on an outpatient basis for consumption at some other location, home health services, outpatient oral surgery, prostheses for outpatient use, or durable medical equipment for use outside the hospital, to the extent that such services are not covered under the other provisions of the CHEP program. Ambulance services and other medical transportation are not hospital services, per se, unless they lead to an inpatient hospital admission and are chargeable as hospital services under the rules and procedures of the Minnesota medical assistance program.

Subp. 17. **Household income.** "Household income" means the gross income of an eligible person and all his dependents 23 years of age or older for the calendar year preceding the year in which an application is filed for CHEPP benefits. A dependent's age, for the purposes of this subpart, shall be his age on the last day of the calendar year preceding the year in which application is filed for CHEPP benefits. Income paid to the applicant or his spouse on behalf of children included in the application shall be considered the applicant's income rather than the children's unless an accounting must be made for its use to some person outside the applicant family; this interpretation of children's income applies in particular to social security survivors' benefits. Child support legally required to be paid to a custodial parent by an absent parent shall be considered income of the custodial parent if and only if the custodial parent is not entitled to claim the child(ren) as tax dependents.

Subp. 18. **Illness.** "Illness" means disease, injury, or a condition involving bodily or mental disorder of any kind, including pregnancy and fertility, and also including the state of reasonable personal concern for maintenance of individual health.

Subp. 19. **Medical assistance program.** "Medical assistance program" means that program of medical assistance to the poor and needy established by title XIX of the federal Social Security Act as of July 1, 1977, and, in Minnesota, by Minnesota Statutes, chapter 256B.

Subp. 20. **Medically necessary.** "Medically necessary" means reasonable and prudent according to commonly accepted standards of medical practice as applied to a particular case at a particular point in time in the light of such information as is or could reasonably be available to the treating physician.

Subp. 21. **Medicare.** "Medicare" means that program of payment for health services for the aged and disabled established by title XVIII of the federal Social Security Act as of July 1, 1977.

Subp. 22. **Nursing home.** "Nursing home" means an institution which is

licensed as a nursing home by the state in which it is located. The term includes facilities which meet the standards of the Minnesota medical assistance program for enrollment as skilled nursing facilities or as intermediate care facilities (I), but it excludes facilities (or beds, in the case of multilevel facilities) which are classified as intermediate care facilities (II) or as intermediate care facilities (mental retardation).

Subp. 23. **Out-of-pocket.** "Out-of-pocket" means the personal liability of an applicant, eligible person, or a dependent of one of these. A charge or expense for a service covered by CHEPP must be an out-of-pocket expense for the applicant or eligible family. Except as provided below, this means that no third party is legally liable to pay it, and no third party has been liable to pay it and has then paid it to or on behalf of the family. If part of an expense for a covered service is paid by a liable third party or is the liability of a third party, that part is not a qualified expense under the CHEP program and may not be used to satisfy the CHEPP deductible and may not be reimbursed by CHEPP. However, expenses for covered services actually paid by liable health insurance companies may be considered eligible out-of-pocket expenses for the purpose of satisfying the CHEPP deductible to the extent that the applicant or one of his dependents actually paid or contributed toward the insurance premiums, the contributions were made during the deductible period, and the services for which the insurance payments were made were received during the deductible period.

Subp. 24. **Physical therapist.** "Physical therapist" means an individual who meets the requirements for enrollment as such in the Minnesota medical assistance program.

Subp. 25. **Physician.** "Physician" means a medical doctor or osteopath, a chiropractor, or a dentist acting within the scope of CHEPP coverage of dental services, licensed in the state in which he practices and acting within the scope of his license. The term does not include podiatrists, optometrists, or psychologists. The inclusion of chiropractors here within the definition of physician shall not imply any authority within the CHEP program for chiropractors to prescribe other health services for coverage under the program if prescribing such services would constitute the prescribing of internal drugs, the practice of medicine, or the practice of physical therapy.

Subp. 26. **Private health care coverage.** "Private health care coverage" means any plan regulated by Minnesota Statutes, chapters 62A, 62C, 62D, or 64A, or sections 62E.01 to 62E.17. Private health care coverage also includes any self-insurance plan providing health care benefits.

Subp. 27. **Provider.** "Provider" means a provider of health services to an applicant for CHEPP benefits or to a CHEPP beneficiary.

Subp. 28. **Qualified expense.** "Qualified expense" means any charge incurred subsequent to July 1, 1977, for a health service which is included in the list of covered services described in Minnesota Statutes, section 62E.06, subdivision 1, and for which no third party is liable. Such qualified expenses shall include the usual and customary charges for the following services and articles when prescribed by a physician:

A. hospital services;

B. professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction;

C. drugs requiring a physician's prescription;

D. services of a skilled nursing facility which meets the requirements for participation as such in the medicare program or the medical assistance program, for not more than 120 days in an individual eligible person's year-long eligibility period, if the services would qualify as reimbursable services under medicare, and if the services do not fall into the class of "qualified nursing home expenses"

defined in subpart 29, and if, in addition, the patient's attending physician certifies in writing that the services are not primarily of a custodial or residential nature;

E. services of a home health agency if the services would qualify as reimbursable services under medicare;

F. use of ionizing radiation or radioisotopes for therapeutic or diagnostic purposes;

G. oxygen;

H. anesthetics;

I. prostheses other than dental, but including cataract lenses;

J. rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;

K. diagnostic X-rays and laboratory tests;

L. oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

M. services of a physical therapist; and

N. transportation provided by licensed ambulance service to the nearest facility qualified to treat a condition, if such ambulance transportation is medically necessary.

Subp. 29. **Qualified nursing home expense.** "Qualified nursing home expense" means any per diem charge (as "per diem charge" is defined by the Minnesota medical assistance program) incurred subsequent to July 1, 1977, for nursing home services after 36 months of continuous care provided to a person less than 65 years of age in a licensed nursing home bed certified at the skilled nursing facility (SNF) or intermediate care facility 1 (ICF-1) level. Periods of inpatient hospital care and short periods of therapeutic leave from nursing home care which occur after the initial admission to nursing home care shall count as part of the 36 months.

Subp. 30. **Reasonable charge.** "Reasonable charge" means the charge for a service or supply which would be allowable for payment under the medical assistance program as administered by the Department of Human Services, except that customary charge audits by provider may be omitted uniformly for practitioners and that determinations of the reasonableness of charges which require professional review may be contracted to a review organization.

Subp. 31. **Regular provider.** "Regular provider" means a provider of health services to a CHEPP applicant or beneficiary who (which) wishes to be reimbursed for such services directly by the CHEP program.

Subp. 32. **Resident of Minnesota.** "Resident of Minnesota" means a person who is presently residing in Minnesota, having there his principal and permanent abode, and having no intent to return to some other state to live upon completion of a course of medical care. In deciding whether an applicant for CHEPP benefits is a resident of Minnesota, all important aspects of the applicant's situation shall be considered, and the decision shall be made on the preponderance of the evidence. In doubtful cases, the following forms of evidence of residence may be included in those examined:

A. the place of residence of the applicant's family members who would be eligible for CHEPP benefits;

B. the number of months that the applicant has lived in Minnesota, and, in the case of retired persons who maintain residences in two or more states, the proportion of each of the past two years which the applicant has spent in Minnesota;

C. the state in which the applicant and his spouse are:

(1) registered to vote;

(2) licensed to drive;

(3) registering their car(s);

(4) claiming a homestead for property tax relief;

(5) employed;

(6) doing their banking; and

D. the state in which the applicant lived for a substantial period before retiring and establishing residences in two or more states.

Subp. 33. **Residual spend-down amount.** "Residual spend-down amount" means any portion of the CHEPP deductible which for administrative convenience is arranged to be deducted from CHEPP payments after an applicant has been accepted as an eligible person.

Subp. 34. **Review organization.** "Review organization" means a professional standards review organization as defined in the federal Social Security Act as of July 1, 1977, or a similar organization as defined in Minnesota Statutes, section 145.61.

Subp. 35. **Subsequent to July 1, 1977.** "Subsequent to July 1, 1977," means on or after July 1, 1977.

Subp. 36. **Third party.** "Third party" means any person other than the eligible person or his dependents.

Subp. 37. **Usual and customary charge.** "Usual and customary charge" means a provider's normal charge, in the absence of insurance or other plan of health coverage, for a service or supply, but not more than the prevailing charge in the state for a like service or supply.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

NOTE: Minnesota Statutes, section 62E.17, was repealed by Laws of Minnesota 1985, First Special Session, chapter 9, article 2, section 104.

9505.1160 APPLICATION.

Subpart 1. **Where to apply.** Applications for benefits from the catastrophic health expense protection program shall be taken by the local welfare agency responsible for the county in which the applicant makes his home.

Subp. 2. **Who may apply.** Applications for CHEPP benefits may be made by a single adult person, by either spouse of a family, or by an individual's attorney, guardian, or personally designated representative, or by the administrator or court-appointed representative of a deceased individual's estate. A personally designated representative shall present written proof of his designation and shall not be an employee of or a contractor with any provider of medical services which has provided services to the applicant. No application may be made on behalf of a deceased person's estate unless the apparent heirs of the estate include the decedent's children, spouse, former spouse, or parents and these do not qualify to apply for CHEPP benefits because of age or relationship to the decendent. An applicant (that is, the person on whose behalf application is made) must be a resident of Minnesota at the time of application.

Subp. 3. **Filing and processing applications.** Application forms and records of applicants' income and expenses for health services shall be kept in the local welfare agency for at least as long as such records are required to be kept by the medical assistance program. Local agencies shall provide copies of CHEPP applications, applicants' medical bills, and other documents submitted at application, to the Department of Human Services as required by the commissioner. Local agencies shall determine whether an applicant is eligible for CHEPP benefits within 30 days of receiving all information and documents needed to determine eligibility. When an applicant has been found eligible, the local agency

shall take whatever action is necessary to establish the applicant family as an eligible case in the state computerized welfare information system, the case information system; this updating of the case information system shall be completed within ten work days of determining the applicant's eligibility.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1170 DELEGATION OF AUTHORITY.

The director of each local welfare agency is designated as the commissioner's agent authorized to review and determine applicants' eligibility for CHEPP benefits. This authority may be further delegated to the supervisor of the administrative unit within each agency which is responsible for processing CHEPP applications.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1180 PROVISION OF INFORMATION BY LOCAL WELFARE AGENCIES.

Local welfare agencies shall answer questions from the public about the CHEP program, using information and literature supplied by the commissioner. Local agencies shall explain the program's benefits and requirements to people who apply or who are eligible for benefits. Local agencies shall explain the state's privacy protection law to people who apply for CHEPP benefits.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1190 CONSIDERATION OF ALTERNATIVE WELFARE PROGRAMS.

Local welfare agencies shall request from CHEPP applicants enough information to decide whether they can qualify for medical assistance, general assistance medical care, or some other form of welfare medical assistance such as certification of need for care at the University Hospitals. Applicants entitled to benefits under such other welfare programs shall be considered ineligible for CHEPP benefits if such other benefits are clearly equal to or greater than those available under CHEPP. If an applicant becomes eligible for CHEPP in preference to some other welfare program to which he is entitled, justification of the selection shall be recorded in the case record.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1200 INFORMATION AND DOCUMENTS TO BE SUPPLIED BY CHEPP APPLICANTS.

Applicants for CHEPP benefits shall provide such information and documents as are needed to establish their eligibility for the program, including as applicable the following:

A. Application data:

(1) full names of family members included in the application;

(2) birthdates of all family members;

(3) current addresses of all family members included in the application;

(4) the main address of the household one month before the date of the first service offered in satisfaction of the CHEPP deductible;

(5) the social security number of each family member whose income would be relevant to determining the family's eligibility for CHEPP benefits;

(6) the amount of the family's household income in the previous year, including an itemization of all such income not reported on a state or federal income tax return or on an application for the Minnesota renter's credit, income-adjusted homestead tax credit, or senior citizen's property tax freeze credit;

(7) the health insurance claim number of each medicare-eligible member of the applicant family;

(8) the names of all private or public plans or programs of health coverage from which one or more family members are entitled to benefits, the addresses of such plans, the policy numbers or beneficiary identification numbers for each plan, and the name of the plan group if necessary for claim filing;

(9) the names of all automobile insurance companies with which family members have no-fault medical coverages, the policy numbers, and the addresses of the companies;

(10) the names of any other third parties who are or may be liable for the cost of health services or health insurance for any family member, and current information about the status of any actions pending or contemplated for recovery of damages or benefits for health services;

(11) the medical assistance program, general assistance medical care, or CHEPP identification number of each family member who has been eligible for one of those programs within the two years before the current application for CHEPP;

(12) the telephone number of the family's main home and the telephone number at work of the employed head of household; and

(13) the sex and marital status of all adult family members.

B. A signed warranty by the applicant that the information supplied is true and complete, to the best of his knowledge and ability to make it such.

C. A signed assignment of third party benefits to the extent of the state's payments on the eligible family's behalf; an assignment shall be signed by the competent family member for each separate set of entitlements; each assignment shall include an authorization to release pertinent medical information for purposes of collecting health plan and other third party benefits for health services.

D. A signed authorization from each family member, other than dependent children under age 23 years, for the commissioner to inspect tax returns and applications for tax credits submitted to the Minnesota Department of Revenue, and for the commissioner to receive copies of such documents pertinent to verifying the income reported by the applicant family; the authority to inspect and receive copies of documents shall extend also to data from microforms and computer storage devices.

E. Copies of invoices from the providers of all health services whose charges are offered in satisfaction of the CHEPP deductible or for CHEPP payment, together with current information as to which charges have been billed to third parties and the extent to which such third parties have paid or are expected to pay for the charges, information as to which charges have been paid by the family out of pocket (with proof of payment), and a signed statement that no insurance company or other third party payment has been received or is expected to be received for charges offered in satisfaction of the CHEPP deductible or for which CHEPP payment is requested, except as explained above.

F. Proof of out-of-pocket payments for prepaid health coverages used to justify partial inclusion of payments by such prepaid plans in the eligible expenses used to satisfy the CHEPP deductible.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1210 CHEPP DEDUCTIBLE.

The CHEPP deductible is out-of-pocket. Eligible expenses offered in satisfaction of the CHEPP deductible must be out-of-pocket expenses and/or liabilities as defined in part 9505.1150, subpart 23. Eligible expenses attributed to the CHEPP deductible need not have been paid in advance of CHEPP eligibility, and failure of an applicant to pay them shall not affect the applicant's eligibility. Payment of such deductible expenses by relatives, friends, or other persons

having no legal duty to pay shall not defeat the out-of-pocket character of the expenses. If a payment by a liable third party is not available within a reasonable period of time (normally 120 days from the date of application), and if the applicant cannot otherwise qualify for the CHEP program, the charges whose payment is in question may be treated as eligible expenses for satisfaction of the CHEPP deductible, provided all required assignments of benefits are signed by the member of the applicant family who appears to be entitled to the delayed or disputed third party payment.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1220 SATISFACTION OF THE CHEPP DEDUCTIBLE.

The applicant for CHEPP benefits may select which of his qualified expenses for services received subsequent to July 1, 1977, is to be the earliest for satisfaction of the CHEPP deductible. Having selected a beginning date, the applicant shall then offer his remaining qualified expenses incurred after that date in satisfaction of the deductible, in the order in which such remaining expenses were incurred. The date of an expense shall be deemed to be the date of the earliest service occasioning any part of the expense or charge. Applicants must be Minnesota residents at the time each service is received whose charge is used to satisfy the CHEPP deductible, but the services may be received in other states.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1230 INCOME CONSIDERED IN SPECIAL CASES.

If a widow or widower applies for CHEPP benefits, the income received prior to death by the deceased spouse which was paid during the calendar year preceding the application year shall be disregarded in determining the CHEPP deductible which must be met by the applicant. Similarly, if an applicant or the applicant's spouse has petitioned for a dissolution of marriage and there exists a temporary decree or other legally binding agreement specifying the terms of separation, the gross income of the nonapplicant spouse shall not be considered in computing the amount of the applicant's CHEPP deductible, provided the applicant is in fact separated from and living apart from the nonapplicant spouse.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1240 DURATION OF ELIGIBILITY.

Subpart 1. **CHEPP 1 benefits.** Eligibility for CHEPP 1 benefits shall run for 12 calendar months, beginning on the first day of the month and year of the earliest service occasioning a qualified expense offered in satisfaction of the CHEPP deductible. Such eligibility shall not cover the portion of any qualified expense offered in satisfaction of the deductible, but it may cover other qualified expenses incurred during the deductible period if such expenses were not known to be qualified at the time of application. Children who reach an age at which they become ineligible for CHEPP benefits during the 12-month period shall remain covered until the last day of the month in which they reach that age.

Subp. 2. **CHEPP 2 benefits.** Eligibility for CHEPP 2 benefits shall run from the date of satisfaction of the CHEPP 2 deductible until the last day of the state fiscal year, this being currently June 30. CHEPP 2 eligibility shall end, however, not later than the last day of the month in which the eligible nursing home patient reaches the age of 65 years.

Subp. 3. **Change of residence.** Eligible persons who establish residence in another state shall be eligible for CHEPP payments for services they receive after their change in residence.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1250 ELIGIBILITY FOR PAYMENT OF QUALIFIED NURSING HOME EXPENSES.

A CHEPP applicant's eligibility for payment of qualified nursing home expenses as defined in part 9505.1150, subpart 29 shall be figured separately from eligibility for other CHEPP benefits. Qualified nursing home expenses as defined in part 9505.1150, subpart 29 shall not be used to satisfy the CHEPP deductible for other CHEPP benefits, and other qualified expenses shall not be used to satisfy the CHEPP deductible for reimbursement of qualified nursing home expenses.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1260 APPLICATION FOR PAYMENT OF QUALIFIED NURSING HOME EXPENSES.

Persons desiring CHEPP payment of qualified nursing home expenses shall apply for payment in a timely way. Application shall be made not later than 60 days after the end of the earliest month for which payment will be requested. Applications for payments for the last month of the state fiscal year, i.e. June, shall be made not later than the last day of the following month.

Persons who wish per diem charges of nursing homes to be limited to those allowed by medical assistance must establish eligibility for CHEPP reimbursement in the month before the month in which the limitation on charges is claimed against the nursing home.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1270 TERMINATION OF ELIGIBILITY.

Subpart 1. **Third party payments.** Eligibility for CHEPP benefits may be terminated or interrupted by the commissioner if third party payments are made for services whose expenses were offered in satisfaction of the CHEPP deductible, regardless of whether they are made to the beneficiary, a provider of care, or the state. If a third party payment interrupts a family's CHEPP eligibility, the commissioner shall notify the family by letter. If the amount of deductible the family must reincur to become eligible for CHEPP again is small, it shall be entered into the computerized central payments system as a residual spend-down amount. Then the family shall be permitted to continue to have medical claims billed to the CHEP program, but amounts payable by the state shall be used to satisfy that residual spend-down before any actual payment is made on a family's behalf. Families which choose to reestablish eligibility for CHEPP benefits in this way are liable to providers of care for both their own copayment amounts and for state-share payments held back to satisfy the residual spend-down. Such families shall tell providers of health services of their interrupted CHEPP eligibility at the time of receiving health services.

Subp. 2. **Fraud.** Eligibility for CHEPP benefits may also be terminated by the commissioner upon a clear determination by the commissioner that incorrect or fraudulent data was submitted by an applicant in order to become eligible. Such a determination shall not be made until 14 days have passed from notice to the family by letter that it is being considered and that the matter may be discussed with a designated representative of the commissioner. If eligibility is terminated because of errors made in good faith in figuring a family's deductible or its satisfaction, the family may be allowed to continue in the CHEP program with the unsatisfied deductible amount being treated as a residual spend-down amount as provided in subpart 1.

Subp. 3. **Return of identification cards.** Families whose CHEPP eligibility is terminated or interrupted to satisfy additional deductible amounts shall return their CHEPP eligibility identification cards to the Department of Human Services, which shall issue replacement cards for families on interrupted eligibility.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1280 APPEALS.

The final decision of the commissioner denying an application for status as an eligible person, suspending it, or revoking it, or denying all or part of the charges for a health service may be appealed by any interested party pursuant to Minnesota Statutes, chapter 14.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1290 BENEFITS PAYABLE.

Subpart 1. **Formula.** Except for qualified nursing home expenses, the Department of Human Services shall pay 90 percent of the reasonable charge for an eligible person's qualified expenses in excess of his CHEPP deductible. The eligible person shall remain liable to the provider of health services for the remaining ten percent of the reasonable charge for each service.

Subp. 2. **Exception.** For qualified nursing home expenses, the Department of Human Services shall pay, at the end of each state fiscal year, an amount for each eligible person calculated as follows, unless some other formula is set by law:

+ (Reasonable cost of eligible person's qualified nursing home care during the state's fiscal year)

- (20 percent of the eligible person's household income in the calendar year before the year application is filed for CHEPP)

= Eligible person's raw entitlement

The CHEP program will not pay more than the raw entitlement, but if there are insufficient funds earmarked for qualified nursing home expenses, the program's payments will be calculated as follows:

$$\text{Payable Amount} = \left(\begin{array}{c}\text{State Appropriation}\\ \text{for qualified}\\ \text{nursing home}\\ \text{expenses}\end{array}\right) \times \left(\frac{\text{Eligible person's raw entitlement}}{\begin{array}{c}\text{The sum of all eligible}\\ \text{persons' raw entitlements}\end{array}}\right)$$

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1300 FORGIVENESS OF DISALLOWED CHARGES.

Subpart 1. **Unconscionable fee.** If a charge for a covered service to an eligible person is billed to CHEPP, any part of the charge determined by the Department of Human Services to be more than a reasonable charge, or the entire charge if the service is determined to have been not medically necessary, shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed. Charges for qualified nursing home expenses shall be considered billed to CHEPP and subject to limitation on the first day of the month following written notice to the nursing home of a patient's eligibility.

Subp. 2. **Nursing home care.** In the case of nursing home care which occasions qualified nursing home expenses, any per diem charge for qualified nursing home care given to a person eligible for CHEPP benefits shall be deemed to be a reasonable charge if it is not more than the charge per diem allowed in that section of that facility for that level of care of the Minnesota medical assistance program.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1310 PERSONS TO WHOM PAYMENTS ARE MADE.

CHEPP 1 benefits shall be paid only to providers of health services, and then

only after receipt of a proper billing for review and adjudication; provided, however, that benefits shall be paid to eligible persons directly if the eligible person has already paid the provider and the services were received before the date of the eligible person's application for CHEPP. CHEPP 2 benefits shall be paid to the eligible nursing home resident or on his behalf to his spouse or guardian.

Statutory Authority: *MS s 62E.54 subd 1*

9505.1320 POSTPAYMENT ADJUSTMENTS.

Adjustments to amounts paid by the CHEPP program shall be settled between the provider and the Department of Human Services at 100 percent, with no payment or collection of copayments to or from CHEPP beneficiaries.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1330 ENROLLMENT OF REGULAR PROVIDERS.

Regular providers of services to CHEPP beneficiaries shall give the Department of Human Services the same enrollment information and provider agreements that are required for enrollment in the medical assistance program, if these have not been given already to the program. Providers already enrolled in the medical assistance program will be enrolled automatically as providers of services for CHEPP beneficiaries unless they ask in writing not to be. Acceptance of payments on behalf of CHEPP beneficiaries by providers enrolled in the medical assistance program shall be deemed to be an acceptance of the terms of parts 9505.1100 to 9505.1380 and to extend the provider's agreement with the medical assistance program to cover services to CHEPP beneficiaries.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1340 INVOICING PROCEDURES.

Subpart 1. **Direct billing to CHEPP.** Regular providers of service to CHEPP beneficiaries shall bill the CHEP program directly, using approved Minnesota medial assistance program invoices and forms. This requirement for billing by providers may be waived by the Department of Human Services for services provided and billed before the date an applicant for CHEPP benefits is told that he or she is eligible.

Subp. 2. **Collection of charges by provider.** If a provider of health services knows that a patient is eligible for CHEPP benefits, other than qualified nursing home expenses, he shall not try to collect charges from the patient or his family for services which are to be billed to CHEPP until the amount of the CHEPP beneficiary's copayment liability has been reported to the provider by the Department of Human Services. A provider may, however, seek third party payments for services to CHEPP beneficiaries, provided that any third party recoveries of charges for services paid for in part by CHEPP are reported to the CHEP program.

Subp. 3. **Prohibition to providers.** Providers who bill the CHEP program shall accept the program's determination of what will constitute reasonable charges for services to CHEPP beneficiaries, and they shall not attempt to collect from beneficiaries any charges disallowed by the program as excessive or as being for services deemed not medically necessary.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1350 THIRD PARTY INSURANCE CLAIMS.

Providers shall bill third parties known to be liable for health services

provided to CHEPP beneficiaries or shall supply sufficient information to the Department of Human Services to allow the department to claim reimbursement under its rights of assignment or subrogation. Providers shall not supply known CHEPP beneficiaries with invoices requesting payment for services to be billed to the CHEP program unless such invoices are prominently marked to indicate that payment by the CHEP program will be or has been requested.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1360 CHEPP BENEFICIARY IDENTIFICATION CARDS.

CHEPP beneficiaries shall be provided with identification cards giving the dates of their eligibility and their identification numbers. Beneficiaries shall show these cards to providers of health services before they receive services for which they expect part payment by CHEPP. CHEPP beneficiaries eligible only for part payment of qualified nursing home expenses shall receive separate and distinct identification cards or letters.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1370 NONQUALIFYING EXPENSES.

Charges for the following shall be considered to be not qualified expenses, not covered by the CHEP program:

A. Cosmetic surgery, except to repair an injury or birth defect.

B. Private hospital or nursing home rooms, to the extent that the charges exceed the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician. If an institution has no semiprivate rooms, its most common semiprivate room charge shall be deemed to be 90 percent of its lowest private room charge.

C. Transsexual surgery.

D. Artificial insemination.

E. Reversals of sterilizations entered into originally with free and informed consent.

F. Autopsies.

G. Missed appointments.

H. Costs of billing.

I. Inpatient psychiatric care substituted for outpatient care primarily to acquire reimbursability of the services under the CHEP program.

Procedures used by the Minnesota medical assistance program for review of the appropriateness or medical necessity of health services shall be used for the review of claims for CHEPP payments to the extent that they are not incompatible with this rule or with the catastrophic health expense protection act. Providers of care shall observe such procedures, including prior authorization procedures, as a condition of receiving payments from the CHEP program.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1380 TERMINATION OF PROVIDER ENROLLMENTS.

Providers may be terminated from enrollment as eligible payees under the CHEP program according to the procedures established for such termination in the Minnesota medical assistance program. Providers terminated from the medical assistance program for misconduct shall be simultaneously terminated from the CHEP program.

Statutory Authority: *MS s 62E.51 to 62E.55*

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

9505.1500 SCOPE AND STATUTORY AUTHORITY FOR EPSDT.

Parts 9505.1500 to 9505.1690 govern the administration of the early and periodic screening, diagnosis, and treatment program (hereinafter referred to as the EPSDT program). This program is mandated by section 1905(a)(4)(B) of the Social Security Act.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1510 PURPOSE OF EPSDT PROGRAM.

The purpose of the EPSDT program is to identify potentially handicapping conditions in children eligible for medical assistance, to provide diagnosis and treatment for conditions identified, and to encourage the entrance of children into the health care system.

Note: It is the intention of the department, in order to ensure effective delivery of EPSDT services, that parents be involved with the child throughout the screening, diagnosis, and treatment process. However, since the program includes "children" through age 20, the department recognizes that some children, including teenagers and adults who are 18 through 20, may be able to supply requested information themselves and may not wish to have their parents involved in the screening process. To allow for such cases, references in parts 9505.1500 to 9505.1690 are made to "parent/child." In using this language, the department intends that health providers and local welfare agencies involve the parent whenever possible in the program, but also recognize the right of the child to privacy.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1520 DEFINITIONS.

Subpart 1. **Child.** For purposes of this rule, "child" means any individual from birth through 20 years of age who is eligible for medical assistance.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

Subp. 3. **Department.** "Department" means the Department of Human Services.

Subp. 4. **Diagnosis.** "Diagnosis" means the determination of the nature or cause of physical or developmental disease or abnormality through the use of health history; physical, developmental, and psychological examination; laboratory tests and X rays.

Subp. 5. **EPSDT equivalent clinic.** "EPSDT equivalent clinic" means a facility which provides screening services according to Minnesota Department of Health EPS standards, provides follow-up services, and is monitored by the Minnesota Department of Health. Such facilities provide comprehensive care in a sequence incompatible with the completion of the EPSDT billing form.

Subp. 6. **EPSDT provider agreement.** "EPSDT provider agreement" means an agreement between a provider of screening services and the department that the provider, in order to qualify for medical assistance reimbursement, will screen each medical assistance child according to the appropriate screening standards specified in parts 9505.1550 and 9505.1560, will report all findings on the EPSDT billing form, and will refer children according to procedures specified in part 9505.1590, subpart 2.

Subp. 7. **Follow-up.** "Follow-up" means efforts by local agencies to ensure that the screening, diagnosis, and treatment services needed by a child are obtained.

Subp. 8. **Local agency.** "Local agency" means the county welfare board, multicounty welfare board, or human service agency established in accordance

with state law and responsible for the administration of the EPSDT program at the county level.

Subp. 9. **Medical assistance.** "Medical assistance" means the program authorized under title XIX of the Social Security Act to provide medical care for individuals whose resources do not enable them to purchase such care.

Subp. 10. **Minnesota Department of Health approved EPS clinic.** "Minnesota Department of Health approved EPS clinic" means an agency which provides screening services according to Minnesota Department of Health screening and administrative standards; which operates under the supervision of a registered nurse, public health nurse, or pediatric/family nurse practitioner; and which qualifies for medical assistance and other public third party reimbursement.

Subp. 11. **Nurse-supervised EPSDT clinic.** "Nurse-supervised EPSDT clinic" means a facility or individual which provides screening services according to Minnesota Department of Health screening standards and Department of Human Services administrative standards. Such clinics operate under the supervision of a registered nurse, public health nurse, or pediatric/family nurse practitioner, and qualify for medical assistance reimbursement.

Subp. 12. **Outreach.** "Outreach" means efforts by the department or local agencies to inform and encourage persons to avail themselves of services which they might not otherwise request without such assistance.

Subp. 13. **Periodic.** "Periodic" means at regular, fixed intervals established for screening by health care experts to assure that disease or abnormality is not incipient or has not appeared since the child's last evaluation.

Subp. 14. **Physician-supervised EPSDT clinic.** "Physician-supervised EPSDT clinic" means a facility or individual which provides screening services according to physician screening standards, which operates under the supervision of a licensed physician, and which qualifies for medical assistance reimbursement.

Subp. 15. **Screening.** "Screening" means the use of quick, simple procedures to sort apparently well children from those who need more definitive study of possible physical or developmental problems.

Subp. 16. **Treatment.** "Treatment" means the use of medical care and services to prevent, correct, or ameliorate disease or abnormalities detected by screening and diagnostic procedures.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

9505.1530 ELIGIBILITY FOR EPSDT PROGRAM.

All persons from birth through age 20 who are eligible for medical assistance are eligible for the EPSDT program.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1540 TERMINATION OF ELIGIBILITY.

Eligibility for the EPSDT program terminates when medical assistance eligibility terminates, regardless of the child's status in the EPSDT process.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1550 PHYSICIAN SCREENING STANDARDS.

Subpart 1. **Requirement.** A licensed physician must provide the following components in order for an examination to be reimbursed as a screening under the EPSDT program.

Subp. 2. **Health history.** A health and developmental history must be obtained from the child, the parent, and/or another responsible adult who is familiar with the child's health history and must include information on lead and tuberculosis exposure, nutrition intake, and seizure history.

Subp. 3. **Assessment of physical growth.** The child's height and weight must be measured and compared with the ranges considered normal for children of that age. Head circumference measurements must be taken for children under three years of age.

Subp. 4. **Physical examination.** The following areas 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 examination.

Subp. 5. **Dental inspection.** The mouth must be examined for any obvious dental problems. A child who is three years of age or older must be referred to a dentist for preventive care if she/he has never been to a dentist or if it has been one year since the last dental appointment.

Subp. 6. **Vision of children under the age of three years.** Children under the age of three years:

A. must be checked for a history of maternal and/or neonatal infection; family history of ocular abnormalities;

B. must be observed for:

(1) pupils and light following reflex;

(2) presence/absence of nystagmus;

(3) muscle balance: examination for esotropia, exotropia, large phorias;

(4) external examination of eyes, including lids, conjuctiva, and cornea; and

(5) parental concern regarding child's vision.

Subp. 7. **Vision of children over the age of three years.** Children over the age of three years:

A. Must be checked for all of the items contained in subpart 6, item A.

B. Must, in addition, be checked for visual acuity. A test such as the STYCAR, the Snellen E Cube, the Snellen E Chart, and the Snellen Alphabet Chart, or their equivalent, must be used.

Subp. 8. **Hearing of children under the age of three years.** Children under the age of three years must be observed for:

A. retardation of language acquisition or history of such retardation;

B. failure to directionalize to sounds;

C. history of repeated otitis media during early life; and

D. parental concern regarding child's hearing.

Subp. 9. **Hearing of children over the age of three years.** Children over the age of three years:

A. must be observed for all of the items contained in subpart 8, items A to D; and

B. must receive a pure tone audiometric test or referral for pure tone audiometric testing if subpart 8, items A to D indicate the need for audiometric testing.

Subp. 10. **Developmental screening.** For children ages birth through five years, the Denver Prescreening Developmental Questionnaire (PDQ) must be completed. All children who fail the PDQ must be screened further by use of the Denver Developmental Screening Test (DDST). If the screener does not provide the DDST, referral must be made to an agency that does provide it.

For children ages six through 20 years, the provider must screen for the following areas according to his/her standard procedures: fine/gross motor development, speech, and socialization. Developmental questions must be included on the health history for this age group.

Subp. 11. **Sexual development.** Sexual development appropriate to the child's age must be checked for all children, with special emphasis given to children who have reached puberty.

At the request of the parent/child, counseling on normal development, birth control and venereal disease, as well as appropriate prescriptions and testing, must be provided by the screener, or referral to appropriate resources must be made.

The option to receive a pelvic examination with appropriate testing (GC, Pap Smear, other tests at provider's discretion) must be offered to all females who have reached puberty.

Subp. 12. **Nutritional status.** A child having any detectable nutritional deficiencies must receive nutritional counseling or must be referred for such counseling.

When a child's history reveals that his/her diet regularly lacks two or more daily servings from one of the four basic food groups, the parent/child must receive nutritional counseling or must be referred for nutritional counseling even if there are no objective signs of poor nutrition.

Subp. 13. **Immunizations.** The immunization status of all children must be checked. Needed immunizations must be offered and provided if requested. Immunizations must be administered according to the Recommended Schedule of Immunizations developed by the Minnesota Department of Health and approved by the Minnesota State Medical Association.

Subp. 14. **Laboratory tests.** Laboratory tests include:

A. Tuberculin testing must be performed for all children once at 15 months of age or at their first screening, if this screening occurs later than 15 months. A child may receive additional tuberculin testing at later ages if his/her history indicates the possibility of exposure.

B. Lead absorption testing must be performed on all children whose history and physical findings indicate the possibility of exposure to undue levels of lead in the environment or atmosphere.

C. Urine testing: all children over the age of two years must be tested at their first screening for the presence of glucose, ketones, protein, and other abnormalities in the urine. Females at or near the ages of four and ten must be tested for bacteriuria.

D. Anemia testing: all children must be tested for anemia by use of either a microhematocrit determination or a hemoglobin concentration. This test should be done near the ages of six months, one year, two years, four years, and 15 years.

E. Sickle cell testing: tests for sickle cell disease or trait must be offered to all children known to be at risk and must be provided if requested by the parent/child. Only one sickle cell test is needed. If sickle cell trait is found, parent/child must be referred for genetic counseling if they so desire.

F. Other laboratory tests: tests for cervical cancer, venereal disease, pregnancy, and parasites should be performed when indicated and charged as part of the screening examination.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1560 VARIATION FROM SCREENING PROCEDURES.

If a provider wishes to substitute other procedures for those contained in part 9505.1550, or wishes to omit any of the required procedures, written application must be made to the EPSDT section in the department. All such requests shall be reviewed by a physician advisory committee and a decision on the request shall be made by the committee in writing within 30 days of the receipt of the request.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1570 NURSE SCREENING STANDARDS.

The department will recognize as screening providers all nurse-supervised EPS and EPSDT clinics which follow the screening standards and periodicity schedule devised by the Minnesota Department of Health. Screenings performed by these providers will be reimbursed under the EPSDT program.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1580 PERIODICITY SCHEDULE.

The department will offer all children who have been screened the opportunity for rescreening at the following ages: six months, nine months, one year, 18 months, two years, four years, and every three years thereafter. The department will notify all eligible recipients of the availability of screening services at least once a year if they have not received an initial screening.

For physician-supervised EPSDT clinics, screening components must be provided according to the physician EPSDT periodicity schedule below.

INTERVALS	MONTHS						YEARS					
	0-5	6-7	8-11	12-15	16-19	20-35	3-4	5-7	8-10	11-13	14-17	18-21
Health History	X	X	X	X	X	X	X	X	X	X	X	X
Assessment of Physical Growth:												
-Height	X	X	X	X	X	X	X	X	X	X	X	X
-Weight	X	X	X	X	X	X	X	X	X	X	X	X
-OFC	X	X	X	X	X	X						
Physical Examination	X	X	X	X	X	X	X	X	X	X	X	X
Dental Inspection	X	X	X	X	X	X	X	X	X	X	X	X
Vision	X	X	X	X	X	X	X	X	X	X	X	X
Hearing	X	X	X	X	X	X	X	X	X	X	X	X
Developmental:												
-PDQ/DDST	X	X	X	X	X	X	X					
-Interview/History Only								X	X	X	X	X
Sexual Development	X	X	X	X	X	X	X	X	X	X	X	X
Nutrition Review	X	X	X	X	X	X	X	X	X	X	X	X
Immunization Review	X	X	X	X	X	←	←	X	←	←	X	←
Tuberculin				X	←	←	←	←	←	←	←	←
Lead Absorption Testing	IF HISTORY INDICATES											
Urine						X	←	←	←	←	←	←
Bacteriuria (females)							X	←	X	←	←	←
Anemia Testing		X	←	X	←	X	X	←	←	←	X	←
Sickle Cell	AT PARENT'S OR CHILD'S REQUEST											
Other Lab Tests	AS INDICATED											

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

Statutory Authority: *MS s 256B.04 subd 2*

9505.1590 CONDITIONS OF SCREENING PROVIDER PARTICIPATION IN THE EPSDT PROGRAM.

Subpart 1. **Billing.** All screening providers must complete the EPSDT billing form with one total charge submitted for the complete screening package.

The parent/child must be provided with a copy of the billing form.

Screening providers which are designated as EPSDT equivalent programs by the department need not complete the billing form. In order to receive such a designation, a facility must screen children according to Minnesota Department of Health standards, must provide follow-up services to those children, and must be monitored by the Minnesota Department of Health. EPSDT equivalent programs may submit screening statistics in aggregate form.

Subp. 2. **Screening referral form.** All screening providers must complete a screening referral form, supplied by the department, and provide this form to the parent/child in every instance when a child is referred for further diagnosis and treatment.

Subp. 3. **Provider agreement.** All screening providers must sign an EPSDT provider agreement whereby they agree to the provisions of subparts 1 and 2.

Subp. 4. **Medical assistance.** In order to qualify for medical assistance reimbursement, screening providers must follow all requirements for medical assistance program participation as specified in parts 9500.0750 to 9500.1080

Subp. 5. **Maximum fees.** All screening providers shall be reimbursed according to their usual and customary fee until six months after parts 9505.1500 to 9505.1690 are published. At that time, the department will establish one maximum screening fee for physician supervised clinics and another maximum screening fee for nurse supervised clinics.

Each of these maximum fees shall be equal to the 75th percentile of all screening charges submitted by each group during that six month period. After the maximum fees are established, screening providers shall be reimbursed according to their usual and customary fee or the department's maximum fee, whichever is lower. The maximum fee shall be updated yearly.

Subp. 6. **Health maintenance organizations.** Health maintenance organizations which participate in the medical assistance program must provide EPSDT services as part of their contract with the department for their enrollees at no extra charge to the department, and must complete the EPSDT billing form for each child screened.

Subp. 7. **Referrals.** Screening providers may, after notifying the department, elect to provide one or more of the screening components by referral to other providers. In such cases, the screening provider must ensure that the child receives the components for which he/she was referred before the screening is billed.

Subp. 8. **Outreach.** Screening providers may provide an outreach component as part of the screening and may charge for the extra outreach service after they have submitted a budget to the department which justifies the outreach charge.

Subp. 9. **Training and assistance.** The department must provide:

A. training on screening components to all providers who sign the EPSDT provider agreement and who request such training; and

B. assistance in obtaining the forms and materials needed in the screening process.

Subp. 10. **Choice of provider.** The parent/child who requests screening services has free choice of all local screening providers who have signed EPSDT provider agreements.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1600 CONDITIONS OF DIAGNOSIS AND TREATMENT PROVIDER PARTICIPATION IN THE EPSDT PROGRAM.

Subpart 1. **Eligibility.** Any health care provider licensed under state law who has signed a medical assistance provider agreement is eligible to provide appropriate diagnostic and treatment services to a child who has been screened.

Subp. 2. **Billing.** Diagnosis and treatment providers must bill according to regular medical assistance procedures as outlined in parts 9500.0750 to 9500.1080. In addition, providers who diagnose or treat a child who has been screened, pursuant to parts 9505.1550 to 9505.1570 must complete the billing invoice so as to indicate that this child is being diagnosed or treated as part of the EPSDT program. The department will make payments according to regular medical assistance procedures as specified in parts 9500.0750 to 9500.1080.

Subp. 3. **Compliance with medical assistance program.** Diagnosis and treatment providers must follow all requirements for medical assistance program participation as specified in parts 9500.0750 to 9500.1080.

Subp. 4. **Choice of provider.** The child or parent of the child who is referred for diagnosis and treatment as a result of a screening has free choice of all local diagnosis and treatment providers who are enrolled in the medical assistance program.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1610 OUTREACH.

Subpart 1. **Screening eligibility.** The local agency must notify all applicants for programs which include medical assistance eligibility about the EPSDT program if the applicant or any of his/her children are under 21 years of age. The notification must include an oral and written explanation of the program. The notification must take place within 30 days of the date of application. The local agency must obtain a definite response in writing from each applicant for each child in the family within 30 days of the date of notification.

Subp. 2. **Rescreening eligibility.** The department will notify, in writing, parents, whose children have been screened, of their eligibility for rescreening at periodic intervals. The department will also renotify parents whose children have never been screened of their continuing eligibility for an initial screening. The local agency will receive the response and must handle the response per parts 9505.1620 to 9505.1660.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1620 RESPONSE TO A SCREENING REQUEST.

Subpart 1. **Written list.** The local agency must provide each parent/child who accepts EPSDT services with a written list of screening providers in the area.

Subp. 2. **Transportation.** The local agency must, in writing, offer transportation to each parent/child who accepts EPSDT services and must provide transportation to the screening site to each child who requests such transportation or for whom such transportation is requested.

Subp. 3. **Other assistance.** The local agency must, in writing, offer assistance in making the screening appointment to each parent/child who accepts EPSDT services and must provide such assistance to each child who requests it or for whom such assistance is requested.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1630 FOLLOW-UP AFTER A SCREENING REQUEST.

The local agency must make one additional offer of assistance to each parent/child who accepted screening services and was not screened within 60 days. This offer of assistance may be done by a home visit, telephone call, or letter.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1640 FOLLOW-UP FOR DIAGNOSIS AND TREATMENT.

Subpart 1. **Written notification.** The department, through the screening provider, will notify each parent/child who is referred for diagnosis and treatment, in writing, that the local agency will provide assistance, including transportation, in obtaining the needed diagnosis and treatment. If requested, the local agency must provide names and addresses of providers of the needed diagnostic and treatment services. If requested, the local agency must provide transportation to the diagnostic and treatment site.

Subp. 2. **Final notification required.** The local agency must make one additional contact, within 60 days of the screening, with each parent/child who was referred for diagnosis and treatment in order to ascertain if needed diagnosis and treatment has been obtained. This contact must be made by either a home visit or telephone call. If a diagnosis and treatment has not been obtained, the local agency must offer assistance, including transportation and/or a list of diagnosis and treatment providers, and must provide such assistance if requested. If the local agency has previously been informed that the child has received the needed diagnosis and treatment, this contact need not be made.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1650 FURTHER NOTIFICATION REQUIREMENT.

Local agencies must provide EPSDT notification and follow-up services to non-English-speaking, illiterate, and disabled applicants and recipients by a mode of communication which will enable them to fully understand and utilize the program.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1660 CHILDREN IN FOSTER CARE ELIGIBLE FOR MEDICAL ASSISTANCE.

Subpart 1. **Requirement.** The local agency must accept EPSDT services for all foster children who are dependent/neglected state wards and who are eligible for medical assistance, except when such acceptance would not be in the best interests of the child.

Subp. 2. **Parental consultation.** The local agency must discuss the availability of EPSDT services with the parents of all foster children who are eligible for medical assistance and who are under the legal custody of the local agency or whose parents have entered into a voluntary placement agreement with the local agency except when the natural parents are not available for such a discussion. If the parent is not consulted, the local agency must decide whether or not to accept EPSDT services for the child and must document the reasons for such a decision. The local agency must assist the parent in deciding whether to accept EPSDT services.

Subp. 3. **Case management services.** The local agency must provide the case management services defined in parts 9505.1620 to 9505.1640 to all foster children for whom EPSDT services are accepted.

Subp. 4. **Rescreening notification.** The department will notify the local agency in writing when foster children who are eligible for medical assistance are eligible for periodic rescreenings. The local agency must handle these notifications as specified in subparts 1 and 2.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1670 DOCUMENTATION.

Local agencies must document the completion of requirements in parts 9505.1610 to 9505.1640 on forms prescribed by the department.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1680 INTERAGENCY COORDINATION.

Local agencies must cooperate, whenever possible, with other agencies which provide health services to children so that duplication of services is avoided. Examples of such agencies are local nursing services, local head start agencies, and local school districts.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1690 REIMBURSEMENT FOR EPSDT STAFF.

Local agencies which intend to claim title XIX federal financial participation at 75 percent for salaries and expenses of EPSDT administrative support staff must obtain written authorization from the department by submittal of a plan that meets state and federal program requirements.

Local agencies which intend to claim title XIX federal financial participation at 75 percent for contracts with outside agencies to perform EPSDT administrative support services must obtain written authorization from the department by submittal of a plan that meets state and federal program requirements.

Statutory Authority: *MS s 256B.04 subd 2*

SURVEILLANCE AND UTILIZATION REVIEW PROGRAM

9505.1750 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 9505.1750 to 9505.2150, the following terms shall be defined as indicated. .

Subp. 2. **Abuse.** "Abuse" means a pattern of practice by a provider, or a pattern of health care utilization by a recipient which is inconsistent with sound fiscal, business, or medical practices, and results 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 care. Abuse is characterized by, but not limited to, the presence of one of the following conditions:

A. The repeated submission of claims by a provider from which required material data is missing or incorrect. Examples include but are not limited to: incorrect or missing procedure or diagnosis codes, incorrect mathematical entries, incorrect third party liability information, incorrect use of procedure code modifiers.

B. The repeated submission of claims by a provider presenting procedure codes which overstate the level or amount of health care provided.

C. The repeated submission of claims by a provider for health care which is not reimbursable under the programs, or the repeated submission of duplicate claims.

D. Failure of a provider to develop and maintain patient care records which document the nature, extent, and evidence of the medical necessity of health care provided.

E. Failure of a provider to use generally accepted accounting principles, or other accounting methods which relate entries on the medical or health care record to corresponding entries on the billing invoice, unless otherwise indicated by federal or state law or rule.

F. The repeated submission of claims by a provider for health care which is not medically necessary, or which is of an unacceptable quality.

G. The repeated submission of claims by a provider for health care which exceeds that requested or agreed to by the recipient or his responsible relative or guardian or that otherwise required by federal or state law or rule; services, prescriptions, or devices deemed unnecessary or excessive under the generally accepted practice of providers of such services, prescriptions, or devices is abusive.

H. The recipient permitting the use of his/her medical identification

card by any unauthorized individual for the purpose of obtaining health care through any of the programs.

I. Obtaining unneeded equipment, supplies, or pharmaceuticals by a recipient for the purpose of resale or the disposal of equipment, supplies, or pharmaceuticals obtained with program moneys without authorization of the local welfare agency.

J. Obtaining duplicate services by a recipient, from a multiple number of providers, for the same health care condition excluding confirmation for diagnosis, evaluation, or assessment.

Subp. 3. **Commissioner.** "Commissioner" means the commissioner of human services or his designee.

Subp. 4. **Health care.** "Health care" means services, equipment, or supplies provided by any individual, organization, or entity that participates in the medical assistance, general assistance medical care, and/or catastrophic health expense protection programs.

Subp. 5. **Health care record.** "Health care record" means written or diagrammed documentation of the nature, extent, and evidence of the medical necessity of health care provided to the program recipients by a provider other than a medical doctor and billed to the programs.

Subp. 6. **Medicaid management information system (MMIS).** "Medicaid management information system (MMIS)" means a centralized automated processing and payment system certified by the United States Department of Health and Human Services and implemented in Minnesota to administer the title XIX program.

Subp. 7. **Medical record.** "Medical record" means written documentation of the nature, extent, and evidence of the medical necessity of health care provided to program recipients by or under the authority of a medical doctor and billed to the programs.

Subp. 8. **Medically necessary.** "Medically necessary" means health care which is rendered pursuant to the provider's authority under state law and within the scope of his/her license, if any, and is:

A. provided in response to life threatening conditions;

B. provided in response to pain;

C. provided to treat injuries, illness, or infections; or

D. provided in compliance with the provisions of parts 9500.0750 to 9500.1080; 9505.1000 to 9505.1040; or 9505.1100 to 9505.1380 regarding services reimbursable under the programs.

Subp. 9. **Pattern.** "Pattern" means an identifiable series of events or activities.

Subp. 10. **Programs.** "Programs" means the Minnesota medical assistance program, the general assistance medical care program, and/or catastrophic health expense protection program.

Subp. 11. **Provider.** "Provider" means an individual, organization, or entity that has entered into an agreement with the state agency to be reimbursed by Minnesota medical assistance, general assistance medical care, and/or catastrophic health expense protection programs for health care provided to a recipient.

Subp. 12. **Recipient.** "Recipient" means an individual who has established eligibility to receive health care paid by Minnesota medical assistance, general assistance medical care, and/or catastrophic health expense protection programs.

Subp. 13. **Records.** "Records" means medical, health care, and financial records pertaining to health care provided program recipients and billed to the programs.

Subp. 14. **State agency.** "State agency" means the Department of Human Services.

Subp. 15. **Surveillance and utilization review (SUR).** "Surveillance and utilization review (SUR)" means the section of the Department of Human Services responsible for the identification and investigation of suspected fraud and abuse by providers and recipients participating in the programs. For the purpose of parts 9505.1750 to 9505.2150, this definition specifically excludes the utilization control activity of the SUR section.

Subp. 16. **Suspending participation.** "Suspending participation" means making a provider ineligible for reimbursement by the programs for a stated period of time.

Subp. 17. **Suspension of payments.** "Suspension of payments" means stoppage of any or all program payments for services billed by a provider pending resolution of the matter in dispute between the provider and the state agency.

Subp. 18. **Terminating participation.** "Terminating participation" means making a provider ineligible for reimbursement by the programs.

Subp. 19. **Utilization control.** "Utilization control" means the activity within the state agency responsible for the ongoing evaluation of the necessity for and the quality and timeliness of services provided in long term care facilities not under the responsibility of a professional standards review organization.

Subp. 20. **Withholding of payments.** "Withholding of payments" means a reduction or adjustment of the amounts paid to a provider for purposes of offsetting overpayments previously made to the provider, or of recovering payments made to a provider for services not documented in the recipient's medical or health care record.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 2; 256D.04 cl (2)*

History: *L 1984 c 654 art 5 s 58*

9505.1760 PURPOSE.

Parts 9505.1750 to 9505.2150 govern procedures to be used by the Surveillance and Utilization Review (SUR) section, Department of Human Services in the identification and investigation of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by a provider or recipient of health care in the Minnesota medical assistance, general assistance medical care, and/or catastrophic health expense protection programs.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

History: *L 1984 c 654 art 5 s 58*

9505.1770 STATUTORY AUTHORITY.

The provisions of parts 9505.1750 to 9505.2150 are to be read in conjunction with titles XVIII and XIX of the federal Social Security Act; Code of Federal Regulations, title 42; Minnesota Statutes, chapters 62E, 256, 256B, 256D and 609; Laws of Minnesota 1980, chapter 349; and other rules of the Minnesota Department of Human Services.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

History: *L 1984 c 654 art 5 s 58*

9505.1780 BULLETINS, MANUALS, AND FORMS.

The Department of Human Services, as the state agency responsible for the administration of the Minnesota medical assistance, general assistance medical care, and catastrophic health expense protection programs, will issue instructional bulletins, manual materials, and forms to assist others in complying with parts 9505.1750 to 9505.2150.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

History: *L 1984 c 654 art 5 s 58*

9505.1790 SCOPE.

Parts 9505.1750 to 9505.2150 are binding on all county welfare boards (hereinafter referred to as local welfare agencies) in the state of Minnesota administering the programs, on all providers of health care participating in the programs, on all recipients under the programs, and on the state agency.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1800 MEDICAL AND HEALTH CARE RECORDS.

Subpart 1. **Documentation requirement.** Medical and health care records must be developed and maintained as a condition for reimbursement by the programs. Program funds paid for health care not documented in the medical and health care record shall be subject to monetary recovery.

Subp. 2. **Legibility.** Medical and health care records shall be legible throughout to at least the individuals providing care.

Subp. 3. **Contents.** Medical and health care records shall contain the following information:

A. Each page of the record shall name or otherwise identify the patient.

B. Each entry in the record shall be signed and dated by the individual providing health care. Record entries for health care provided by an individual under the supervision of an individual licensed provider, and which is billed directly to the programs by the provider, shall be countersigned by the provider. Institutional providers shall not be required to countersign record entries for health care provided in the facility by an individual provider; however, the institutional providers shall be responsible for monitoring the provision of such health care.

C. Diagnoses, assessments, or evaluations.

D. The patient case history and results of oral or physical examination.

E. The plan of treatment or patient care plan shall be entered in the physical record or shall be otherwise available on site.

F. Quantities and dosages of any prescribed drugs ordered and/or administered shall be entered in the record.

G. The results of all diagnostic tests and examinations.

H. The record shall indicate the patient's progress, response to treatment, any change in treatment, and any change in diagnosis.

I. Copies of consultation reports relating to a particular recipient.

J. Dates of hospitalization relating to service provided by a particular provider.

K. A copy of the summary of surgical procedures billed to the programs by the provider.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1810 RECORDS EXCEPTION.

Subpart 1. **Applicability.** The requirements of item C shall not apply to pharmacies, laboratories, ambulance services, and medical transportation providers, or suppliers of medical equipment and nondurable supplies.

Subp. 2. **Records required.** For the purpose of parts 9505.1750 to 9505.2150, provider groups mentioned in this part shall develop and maintain the following records:

A. Pharmacies:

(1) Prescriptions or equivalent computer record.

(2) This part shall not require the development and maintenance of a recipient drug profile; however, if available, the state agency shall be authorized to review such a record.

B. Laboratories:

(1) Documentation of provider orders for laboratory tests or procedures.

(2) Documentation of test results.

C. Ambulance service and medical transportation providers:

(1) Documentation of physician authorization for nonemergency medical transportation.

(2) Trip tickets.

(3) Documentation of durable and nondurable supplies expended on a recipient.

D. Suppliers of medical equipment and nondurable supplies:

(1) Prescriptions.

(2) Documentation of physician orders related to the provision of equipment and supplies.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1820 FINANCIAL RECORDS.

Subpart 1. **Requirement.** Financial records pertaining to the provider's costs, if the provider is reimbursed on a cost basis, and charges for health care provided to program recipients shall be developed and maintained.

Subp. 2. **Contents of records for all providers.** Financial records for all providers, other than nursing homes and board and care homes certified by the Department of Health, shall include:

A. purchase invoices;

B. all accounting records including, but not limited to, payroll ledgers, canceled checks, and bank deposit slips;

C. all contracts for supplies and services which relate to the provider's costs and charges for health care billed to the programs;

D. evidence of the provider's usual and customary charges and written evidence of charges to nonrecipient patients without violating nonrecipient patient rights to confidentiality; and

E. evidence of claims for reimbursement, payments, settlements, or denials resulting from claims submitted to other third party payers of health care.

For the purposes of parts 9505.1750 to 9505.2150, third parties shall include other governmental programs, insurance companies, no-fault auto insurers, and other payers of health care who may be financially responsible for services rendered a recipient.

Subp. 3. **Contents of records for nursing homes and board and care homes.** Financial records for nursing homes and board and care homes certified by the Department of Health, shall include all records identified in subpart 2 and records of deposits and expenditures for patient personal needs allowance accounts.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1830 ACCESS TO RECORDS.

For the purposes of parts 9505.1750 to 9505.2150, as set forth in part 9505.1760, providers shall grant the state agency access during regular business hours to examine medical, health care, and financial records related to health care billed to the programs. Access to a recipient's personal medical and health care record shall be for the purpose of investigating whether or not a provider has submitted a claim for reimbursement, a cost report, or a rate application which may be false in whole or in part or whether or not the health care was medically necessary. The SUR section shall notify the provider at least 24 hours before gaining access to such records. Upon the request of the provider, the SUR section

shall present a copy of the recipient's written authorization to examine personal medical records unless the provider already has received written authorization from the recipient. A provider's refusal to grant the state agency access to examine records when authorized shall be grounds for sanction.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1840 COPYING RECORDS.

The state agency, at its own expense, is authorized to photocopy or otherwise duplicate any medical or financial record which it is authorized to examine. Photocopying shall be limited to the provider's premises unless removal is specifically permitted by the provider.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1850 RETENTION OF RECORDS.

Providers shall retain all records for at least five years. Records may be microfilmed after the third year.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1860 CHANGE OF OWNERSHIP.

In the event of a change of ownership of a facility or practice the seller, unless otherwise provided by law or by written agreement, shall be responsible for maintaining and preserving all records generated prior to the date of sale. Responsibility for making records available for inspection after the date of sale is on the seller and the seller must take reasonable steps by contract or otherwise to maintain a right of access to those records which is necessary to substantiate his billings, cost reports, or rate applications.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1870 PROVIDER WITHDRAWAL OR TERMINATION.

In the event a provider withdraws or is terminated from the programs, all records developed during participation in the programs, and not subject to the provisions of part 9505.1860, shall be retained by the provider for a period of five years and shall be available for review by the state agency. Providers must retain records for at least five years after the date of billing.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1880 RECIPIENT CONSENT TO REVIEW OF RECORDS.

A recipient's consent to the state agency's review of his or her medical or health care records shall be presumed competent if given in conjunction with an application for coverage under the programs. This presumption shall be rebuttable, and shall exist regardless of whether the application was signed by a recipient or a guardian.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1890 IDENTIFICATION OF SUSPECTED FRAUD AND ABUSE.

Subpart 1. **Duties of SUR.** SUR shall be responsible for the detection and identification of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by providers who have billed the programs for health care rendered to a recipient.

Subp. 2. **Authorization to use information.** For the purposes of parts 9505.1750 to 9505.2150, SUR shall be authorized to utilize information from sources which shall include, but not be limited to:

A. units of local, state, and federal government;

B. other third-party payers including health insurance carriers;

C. professional standards review organizations;

D. citizens, including recipients;

E. providers, professional associations, and health care professionals; and

F. computer reports generated by MMIS, using claim data to develop profiles on the provision and utilization of health care reimbursed by the programs. The profiles compare data on a peer group basis, and identify providers and recipients who appear exceptional when compared to group norms.

Subp. 3. **Assessment and consultation.** In assessing questions of abuse or medical necessity, SUR shall consult with a review organization as defined in Minnesota Statutes, section 145.61 or other provider advisory committees as appointed by the commissioner.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1900 INVESTIGATION OF SUSPECTED FRAUD OR ABUSE BY PROVIDERS.

Subpart 1. **Duties of SUR.** SUR shall be responsible for the investigation of suspected fraud and abuse identified pursuant to part 9505.1890. An investigation shall be conducted for the purposes of determining one or more of the following:

A. whether the suspected aberrant activity of a provider is the result of a legitimate condition of practice;

B. whether suspected fraud and abuse exists and can be documented;

C. whether sufficient evidence can be developed to support administrative, civil, or criminal action as to such fraud and abuse.

Subp. 2. **The investigation.** A SUR investigation may include, but is not limited to:

A. examination of records pursuant to parts 9505.1800 to 9505.1880;

B. interviews of providers, their associates, and employees;

C. interviews of program recipients;

D. verification of the professional credentials of providers, their associates, and employees;

E. examination of any equipment, stock, materials, or other items used in or for the treatment of program recipients;

F. examination of prescriptions written for program recipients; and

G. determination of whether the health care provided was medically necessary.

Subp. 3. **Postinvestigation action.** Following the completion of an investigation, SUR shall take one or more of the following actions:

A. determine that no further action is warranted and so notify the provider;

B. impose administrative sanctions against a provider in accordance with part 9505.1910;

C. seek monetary recovery from a provider as set forth in part 9505.1910; and

D. refer the case in writing to the attorney general for possible civil or criminal legal action.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1910 MONETARY RECOVERY AND SANCTIONS AGAINST PROVIDERS.

The commissioner shall be authorized to seek monetary recovery or impose administrative sanctions to protect the public welfare and the interests of the

program. Monetary recovery and sanctions implemented by the commissioner shall be based upon documentation of fraud and abuse as set forth in parts 9505.1890 and 9505.1900.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1920 GROUNDS FOR MONETARY RECOVERY FROM PROVIDERS.

The commissioner may seek monetary recovery against providers for any of the following:

A. fraud, theft, or abuse in connection with health care services billed to the programs;

B. presentment of false or duplicate claims, or claims for services not medically necessary; and

C. false statement of material facts for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1930 GROUNDS FOR IMPOSITION OF ADMINISTRATIVE SANCTIONS AGAINST PROVIDERS.

The commissioner may impose administrative sanctions against providers for any of the following:

A. fraud, theft, or abuse in connection with health care services billed to the program;

B. a pattern of presentment of false or duplicate claims or claims for services not medically necessary;

C. a pattern of making false statement of material facts for the purpose of obtaining greater compensation than that to which the provider is legally entitled; and

D. refusal to grant the state agency access to records pursuant to part 9505.1830.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1940 EFFECT OF FRAUD OR ABUSE OF MEDICARE PROGRAM.

The commissioner shall suspend or terminate any provider who has been suspended or terminated from participation in the medicare program because of fraud or abuse in connection with the title XVIII of the Social Security Act.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1950 METHODS OF MONETARY RECOVERY FROM PROVIDERS.

The commissioner shall make monetary recovery from providers of moneys erroneously paid due to violations described in part 9505.1920 by the following means:

A. permitting voluntary repayment by the provider of moneys erroneously paid, either in lump sum payment or installment payments;

B. withholding of payments;

C. debiting from program payments, moneys determined to have been erroneously paid; and

D. using any legal process to collect such moneys.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1960 USE OF RANDOM SAMPLE EXTRAPOLATION.

Subpart 1. **Authorization.** For the purpose of part 9505.1950, the commissioner shall be authorized to make monetary recovery from providers of moneys erroneously paid, based upon extrapolation from systematic random samples of claims submitted by a provider and paid by the programs.

Subp. 2. **Decision to use samples.** The decision to use sampling and extrapolation in calculating a monetary recovery shall be at the discretion of the director of the SUR section. The following criteria shall apply in determining whether the sampling technique will be used:

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

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

C. the claims to be sampled constitute charges to the department of more than $2,000.

Subp. 3. **Sampling method.** The following factors shall apply in determining recovery by sampling and extrapolation:

A. Samples shall be selected such that every claim to be sampled has an equal and independent chance of being chosen for the sample.

B. Samples shall only be selected from claims within a time period which coincides with the duration of the violations for which recovery will be made.

C. The sampling method, to include sample size, sample selection, and extrapolation from the results of the sample, shall be in accordance with statistical procedures published in the following texts: L. Kish, Survey Sampling, John Wiley and Sons, New York (1965), or W. Cochran, Sampling Techniques, John Wiley and Sons, New York 3rd Ed. (1977).

D. Samples shall be selected at the 95 percent confidence level, such that, the overall monetary recovery amount determined by extrapolation from the sample recovery amount will be within five percent of the amount which would be recovered by a complete audit, 95 percent of the time. The department will recover the extrapolated amount less the five percent factor.

Subp. 4. **Notice of intent to use samples.** The department shall notify the provider of its intent to use sampling and extrapolation. The notice shall state the nature of claims to be sampled, the sample size, the sample selection method, and the formulas and calculators to be used in extrapolation.

Subp. 5. **Rebuttable sampling results.** The monetary recovery proposed by the department, based upon the use of sampling and extrapolation is rebuttable. The provider may present, at a conference with the SUR director, material to rebut the sample size and design, the facts and conclusions drawn from each sample used, and the calculations used to extrapolate the sample findings to all services furnished for the period of time reviewed. The costs of gathering and presenting the information will be met by the provider. Alternatively, the provider, at his expense, may conduct a complete audit and use the results to rebut the department's findings.

Subp. 6. **Appeal procedure.** If the department does not accept the provider's rebuttal, the provider may appeal under procedures cited at part 9505.2150.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1970 SANCTIONS AGAINST PROVIDERS.

The commissioner may impose any of the following sanctions for the conduct described in part 9505.1930:

A. referral to the appropriate state regulatory agency;

B. referral to the appropriate peer review mechanism;

C. transfer to a provider agreement of limited duration not to exceed 12 months;

D. transfer to a provider agreement which stipulates specific conditions of participation; and

E. suspending or terminating participation.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1980 NOTICE TO PROVIDERS OF AGENCY ACTION.

Subpart 1. **Requirement.** The state agency shall notify providers in writing of any recovery of money or sanction it intends to impose.

Subp. 2. **Contents.** The notice shall state:

A. the factual basis for alleging discrepancies or violations;

B. the dollar value to such discrepancies or violations;

C. how such dollar value was computed;

D. what actions the state agency intends to take;

E. the provider's right to dispute the state agency's factual allegations and to provide evidence to support the provider's position; and

F. the provider's right to appeal the state agency's proposed action pursuant to part 9505.2150.

Subp. 3. **Effective date of recovery or sanction.** The effective date of the proposed monetary recovery or sanction shall be at least 20 calendar days following receipt of certified mail notifying the provider of the proposed action. If the provider appeals pursuant to part 9505.2150, the action shall not be implemented until the commissioner's order is issued following the hearing on appeal, provided that the suspending or withholding of payment shall be effective on the date the notice is received, if in the commissioner's opinion such action is necessary to protect the public welfare and interests of the program. However, the commissioner shall not order a prehearing suspension or withholding of payments to a nursing home or board and care home. Implementation of a proposed action following the hearing on appeal may be postponed if in the opinion of the commissioner the delayed action is necessary to protect the welfare or interests of program recipients.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1990 COMMISSIONER TO DECIDE IMPOSITION OF SANCTION AGAINST PROVIDER.

The decision as to the sanction to be imposed against a provider, pursuant to part 9505.1930, shall be at the discretion of the commissioner. The following factors shall be considered in determining the sanctions to be imposed:

A. nature and extent of offenses or violations;

B. history of prior violations;

C. provider's willingness to obey program rules; and

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

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2000 SUSPENSION OR TERMINATION OF PROVIDER PARTICIPATION.

Suspension or termination from participation shall preclude a provider from submitting any claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association for any health care provided under the programs, except for health care provided prior to the suspension or termination.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2010 PROHIBITED SUBMISSION OF PROVIDER'S CLAIMS.

No clinic, group, corporation, or other association which is a provider of services shall submit any claim for payment for any health care provided by an individual provider within such organization who has been suspended or terminated from participation in the programs, except for health care provided prior to the suspension or termination. The state agency shall seek monetary recovery of such claims. Knowing submission of such claims shall be a ground for administrative sanction.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2020 AGENCY NOTICE OF PROVIDER'S SANCTIONS.

When a provider has been sanctioned in accordance with part 9505.1960, after all appeals have been exhausted or the time in which to file an appeal has elapsed, the state agency 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 subsequent appeal.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2030 MONEY RECOVERY AND SANCTIONS AGAINST PROVIDERS.

Nothing in parts 9505.1750 to 9505.2150 shall prevent the commissioner from simultaneously seeking monetary recovery and imposing sanction against a provider.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2040 ROUTINE AUDITS OF PROVIDERS.

Nothing in parts 9505.1750 to 9505.2150 shall prohibit SUR from conducting routine audits of providers in order to monitor compliance with program requirements.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2050 SUSPENSION OR WITHHOLDING OF PAYMENTS TO PROVIDERS PRIOR TO A HEARING.

The commissioner is authorized to suspend or withhold payments to a provider prior to a hearing, as provided in part 9505.1980, subpart 3, if:

A. there is a substantial likelihood of prevailing in an action pursuant to parts 9505.1910 to 9505.2040; or

B. there is a substantial likelihood that the provider's pattern of practice which prompted a SUR investigation, will continue in the future; or

C. there is reasonable cause to doubt a provider's financial ability to refund any amounts determined to be due the program.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2060 FEDERAL LAW PREVAILS.

To the extent that federal law or regulation mandates sanctions against providers or recipients which conflict with provisions of parts 9505.1750 to 9505.2150, such federal law or regulation shall prevail.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2070 IDENTIFICATION OF SUSPECTED FRAUD AND ABUSE BY RECIPIENTS.

Subpart 1. **Duties of SUR.** SUR shall be responsible for the detection and investigation of suspected fraud, theft, or abuse by recipients of the programs.

Subp. 2. **Information available.** For the purpose of parts 9505.1750 to 9505.2150, SUR shall be authorized to utilize at least the sources of information identified in part 9505.1890, subpart 2.

Subp. 3. **Assessment of medical necessity.** In assessing the question of medical necessity, SUR shall consult with a review organization as defined in Minnesota Statutes, section 145.61 or other provider advisory committees as appointed by the commissioner.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2080 INVESTIGATION OF SUSPECTED FRAUD AND ABUSE BY RECIPIENTS.

SUR shall be responsible for the investigation of suspected fraud and abuse

identified pursuant to part 9505.2070. A SUR investigation shall be conducted for the purpose of determining:

A. whether suspected fraud, theft, or abuse exists and can be documented;

B. whether sufficient evidence can be developed to support restricting recipient participation in the programs in accordance with parts 9505.2090 to 9505.2140; and

C. whether sufficient evidence exists to support the imposition of other sanctions in accordance with parts 9505.2090 to 9505.2140.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2090 GROUNDS FOR SANCTIONS AGAINST RECIPIENTS.

SUR may impose administrative sanctions against program recipients for any of the following:

A. altering or duplicating the medical identification card in any manner;

B. permitting the use of his or her medical identification card by any unauthorized individual for the purpose of obtaining health care through the programs;

C. using a medical identification card that belongs to another person;

D. using the medical identification card to assist any unauthorized individual in obtaining health care for which the programs are billed;

E. duplicating or altering prescriptions;

F. knowingly misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, or drugs;

G. knowingly furnishing incorrect eligibility status or information to a provider;

H. knowingly furnishing false information to a provider in connection with health care previously rendered which the recipient has obtained and for which the programs have been billed;

I. knowingly obtaining health care in excess of established program limitations, or knowingly obtaining health care which is clearly not medically necessary;

J. knowingly obtaining duplicate services from a multiple number of providers for the same health care condition, excluding confirmation of diagnosis; or

K. otherwise obtaining health care by false pretenses.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2100 SANCTIONS AGAINST PROGRAM RECIPIENTS.

SUR may impose any of the following sanctions for the conduct described in part 9505.2090:

A. referring the recipient for appropriate health counseling in order to correct inappropriate or dangerous utilization of health care;

B. referring the recipient to the attorney general for possible criminal or civil legal action;

C. recovery from recipients, to the extent permitted by law all amounts incorrectly paid by the programs;

D. terminating participation for that period during which a potential recipient refuses to sign a consent for release of records; or

E. restricting the recipient's participation in a program to receiving health care from a provider whom the recipient has had the opportunity to select.

The restriction shall be for a specified period of time and all changes in the designation of a provider during the restriction period shall be approved by the

state agency. Reimbursement for nonemergency health care shall be limited to the designated provider.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2110 NOTICE TO RECIPIENTS OF SANCTIONS.

The state agency shall cause the recipients to be notified in writing of any sanction it intends to impose.

The notice shall state:

A. the factual basis for alleging discrepancies or violations;

B. the dollar value to such discrepancies or violations;

C. how such dollar amount was computed;

D. what actions the state agency intends to take;

E. the recipient's right to dispute the state agency's factual allegations; and

F. the recipient's right to appeal the state agency's proposed action pursuant to part 9505.2150.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2120 REIMBURSEMENT FOR EMERGENCY HEALTH CARE OF A RESTRICTED RECIPIENT.

Emergency health care provided a restricted recipient by any provider shall be eligible for reimbursement by the programs if the claim for reimbursement is accompanied by a full explanation of the emergency circumstances.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2130 SPECIALIZED HEALTH CARE OF RESTRICTED RECIPIENT.

The programs shall pay for specialized health care provided a restricted recipient if a copy of the written referral by the recipient's chosen provider is sent to the SUR section.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2140 RESTRICTION TO BE INDICATED ON MEDICAL CARD.

The fact that a recipient is restricted shall be clearly indicated on the medical card.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2150 APPEAL OF AGENCY ACTIONS.

Subpart 1. **Provider's right to appeal.** A provider may appeal the state agency's proposed administrative sanction, proposed suspension or withholding of payment, or demand for monetary recovery against a provider pursuant to the provisions of Minnesota Statutes, sections 14.57, 14.58, and 14.59 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner within 20 days of the date notice is received pursuant to part 9505.1980.

Subp. 2. **Recipient's right to appeal.** A recipient may appeal any sanction proposed by the state agency pursuant to the provisions of Minnesota Statutes, section 256.045.

Subp. 3. **Informal discussion of issues.** Nothing in parts 9505.1750 to 9505.2150 shall prevent a provider or recipient, upon receipt of a notice of intended sanction, from meeting with the commissioner to informally discuss the matter in dispute, so long as an appeal has not been commenced.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

PREADMISSION SCREENING PROGRAM

9505.2250 RESPONSIBILITY FOR THE PREADMISSION SCREENING PROGRAM.

The county agency responsible for administering the medical assistance program in each participating county shall be responsible for complying with requirements of the preadmission screening program.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2260 PROGRAM SCOPE.

In counties participating in the program, screening teams shall review and make recommendations for nursing home applicants who are eligible for medical assistance and those who will be eligible within 90 days of admission to a nursing home. If an applicant or recipient's county of financial responsibility is included in the screening program, such applicant or recipient must be screened by the county of financial responsibility for admission to any nursing home. The procedures and criteria used by the screening team shall be in accordance with parts 9505.2300 to 9505.2340. Participating counties shall be eligible for the alternative care grant program described in part 9505.2340.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2270 NOTICE TO ELIGIBLE PERSONS.

The county agency responsible for the screening program shall refer to a screening team all persons eligible for the screening as described in part 9505.2260. When possible, medical assistance recipients shall be notified of the screening requirement through a direct mailing by the local welfare agency. At the time of the referral, with the consent of the applicant, the local welfare agency shall notify a responsible party or appropriate relative that the person has been referred, and the preadmission screening is a condition of medical assistance coverage.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2280 PUBLIC NOTICE OF SCREENING REQUIREMENT.

The county agency responsible for the screening program shall provide public notification of the screening requirement. The methods of public notification shall include publication in available appropriate newsletters, display and dissemination of information leaflets in a readable form and in accessible locations, and promotion through other local media sources. The public notification shall include information on how to contact the screening team, implications of the screening team's recommendations, and the individuals' rights to appeal the screening team's recommendations.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2290 NOTICE TO OFFICIALS AND HEALTH CARE PROFESSIONALS.

The Department of Human Services shall provide formal notification about the screening program to county commissioners, local health and welfare agencies, state hospitals, nursing homes, and physicians. The department shall assist participating counties in providing information sessions and materials to further explain the program.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

History: *L 1984 c 654 art 5 s 58*

9505.2300 RESOURCE MATERIAL FOR SCREENING PROGRAMS.

Subpart 1. **Screening tool.** The department shall recommend a screening tool to be used as a guide in conducting the screening interview. The screening tool recommended by the department shall obtain consistent categories of informa-

tion and ensure that persons are receiving uniform screening. The assessment tool used by the county screening teams shall require information related to the following criteria:

A. present medical conditions;

B. present unmet needs;

C. informal and formal service available or being provided to the person;

D. the recipient's preferences;

E. persons consulted in the screening process;

F. observations of the screening team during the onsite visit;

G. assessment of functional capacity; and

H. a preliminary service care plan.

The state agency shall allow counties flexibility in using the recommended tool or a comparable one which includes the information related to the criteria in items A to H and has been approved by the state agency.

Subp. 2. **Technical assistance.** Department staff shall be available to provide technical assistance in conducting the screenings, including special training sessions.

Subp. 3. **Directory of services.** The county agency shall develop a resource directory of available institutional and noninstitutional services to be used by the screening team in determining how well an applicant's needs can be met by existing community services.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2310 SCREENING REQUIREMENTS.

Subpart 1. **Screening team.** Minnesota Statutes, section 256B.091, subdivision 2, shall govern the composition of the screening team. The screening team must include a public health nurse from the local public health nursing service, a social worker from the local community welfare agency, a physician available for consultation when necessary, and the individual's physician if the physician chooses to participate. The screening team shall utilize the individual's attending physicians' assessment forms if available.

Subp. 2. **Screening procedures.** The screening team shall notify the individual's attending physician that the screening is a condition of medical assistance and that the physician has the right to participate in the screening procedure. The screening team shall begin the screening process within five working days after receiving the request, and it shall issue a recommendation within ten working days after receiving the request. The screening team shall notify the applicant or appropriate relative or responsible party of the decision. The team shall also notify the referring physician, the referring local welfare department if the applicant is a medical assistance recipient, and the nursing home if placement is recommended.

Subp. 3. **Rescreening procedures.** Reconsideration of a previously denied application shall be given when there has been a change in circumstances. The application shall be resubmitted to the screening team with a written explanation of the change in circumstances. Time requirements for initial applications shall apply.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2320 CRITERIA FOR SCREENING TEAM RECOMMENDATIONS.

Subpart 1. **Nursing home admission.** The screening team shall recommend admission to a nursing home when it is determined that the individual requires care or services which are not available to the recipient outside of the nursing home and cannot be provided through the alternative care grants program. In

assessing the individual's need for service, the screening team may use reliable information gathered by others.

Subp. 2. **Use of community services.** The screening team shall not recommend admission to a nursing home when it is determined that the individual can remain in the community and that care and services are available to the individual in his or her own community.

Subp. 3. **Choice of care.** The recipient or his or her representative shall be informed of all feasible alternatives and allowed to choose among them where the cost of home and community-based services are not expected to exceed the cost of the appropriate level of nursing home care. This choice shall be recorded and maintained in the individual's plan of care.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2330 PLAN OF CARE.

Subpart 1. **Requirement.** A recommendation for the applicant to remain in the community shall be accompanied by a plan of care including referral to service providers and assignment of responsibility for implementing the plan.

Subp. 2. **Development of the plan.** The plan of care shall be developed by the screening team in consultation with the individual, the treating physician, and appropriate family members or responsible parties. The resource directory described in part 9505.2300, subpart 3 shall be used in determining what services are available.

Subp. 3. **Services provided in the plan of care.** Where the plan of care includes services that are not available at that time through other public assistance sources, the services shall be provided through an alternative care grant described in part 9505.2340.

Subp. 4. **Responsibility for the plan of care.** The plan of care shall include the name of the person responsible for ensuring compliance, the method of monitoring the recipient's acceptance of and adjustment to the services provided under the plan, the date for reevaluation, and any temporary measures that might be required immediately in order to ensure the safety of the person. When needed services become unavailable, the assigned person shall be responsible for recommending a reevaluation by the screening team.

Subp. 5. **Cost-effective alternatives.** The plan of care shall include documentation that the most cost-effective alternatives available have been offered to the individual.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2340 ALTERNATIVE CARE GRANT.

Subpart 1. **Use of grant.** The grant shall be used to provide services to medical assistance recipients who have been screened and found appropriate for home or community care. Services that may be provided through this grant are day care, case management, homemaker, home health aide, personal care, respite care, foster care, and others for which federal participation is provided under the Social Security Act, section 1915, as added by Public Law Number 97-35, as amended through December 31, 1981. The grant shall supplement but not supplant services available through other public assistance or service programs. The grant shall not be used to establish new programs for which public money is available through other sources.

Subp. 2. **Service provision.** The services shall be provided by a licensed health care provider; a home health service eligible for reimbursement under United States Code, title 42, subchapters XVIII or XIX, as amended through December 31, 1981, and Code of Federal Regulations, title 42, sections 405.1201 to 405.1230 (1981); or by persons employed by, or under contract to, the county board or the local welfare agency.

Subp. 3. **Reimbursement of services.** Services shall be reimbursed at a level no greater than that which is allowed under United States Code, title 42, subchapters XIX and XX, as amended through December 31, 1981, and Code of Federal Regulations, title 42, sections 405.201 to 405.252 (1981), unless lower rates are negotiated with providers at a level sufficient to insure the availability of such services in the community.

Subp. 4. **Assurances.** The county shall provide the commissioner of human services with assurances that the alternative care grant is used for purposes specified in Minnesota Statutes, section 256B.091, subdivision 8 and in Public Law Number 97-35, section 2176 relating to community-based services.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

History: *L 1984 c 654 art 5 s 58*

9505.2350 REIMBURSEMENT OF NURSING HOME COSTS.

Subpart 1. **Notification of admission of unscreened applicants.** When an individual covered by the mandatory screening requirement is admitted to a nursing home on an emergency or nonemergency basis and has not obtained the required preadmission screening, the nursing home shall notify the screening team within two working days. If the admitting facility fails to contact the screening team within the prescribed period, the facility shall not be reimbursed for any costs incurred until the decision is made and the recipient and the nursing home are notified. Patient days resulting from that stay must be counted in the facility's patient day statistics for the purposes of rate calculation under parts 9510.0010 to 9510.0480.

Subp. 2. **Screening team review.** When an unscreened applicant has been admitted to the nursing home, the screening team shall make a decision on the case within five working days of being contacted by the nursing home. If the person prefers to return to the community, medical assistance shall cover the costs only for the period through the date the screening team notified the nursing home of this decision and until a plan for alternative care can be implemented.

Subp. 3. **Persons not screened.** Nursing home applicants who have not been screened and are not medical assistance recipients shall be asked by the nursing home if they have sufficient funds to cover 90 days of nursing home care or whether they will be applying for medical assistance within that time period. If, based on the information given and recorded, the nursing home determines that the person is not subject to the screening requirement the applicant may be admitted without screening. The nursing home shall maintain documentation of the basis for this decision in the patient's file. If the patient's statement concerning proposed eligibility is inaccurate, the health care facility shall not be denied reimbursement because of the inaccuracy of this statement.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2360 REIMBURSEMENT FOR SCREENING COSTS.

Subpart 1. **Persons eligible for medical assistance.** The Department of Human Services shall reimburse the county agency for the preadmission screening required for persons who are eligible for medical assistance and those who will be eligible for medical assistance within 90 days of admission to a nursing home. Reimbursement shall be in a manner agreed upon by both parties.

Subp. 2. **Persons not receiving assistance.** The Department of Human Services shall reimburse the county agency for all or a portion of the cost of screening for a person whose costs are not reimbursed under subpart 1. The percentage rate of reimbursement by the department shall be determined according to the schedule in subpart 3, except that the maximum amount of reimbursement from the department for a screening shall not exceed the maximum reimbursement available to a county agency for the cost of a screening reimbursed under subpart 1. The county agency may assess the person who is screened for the part of the screening cost not reimbursed by the department.

Subp. 3. **Reimbursement schedule.**

Annual Gross Income per Individual	Screening Fee Reimbursement for Applicants Not Eligible for Medical Assistance
under - 13,000	100 %
13,001 - 13,500	90
13,501 - 14,000	80
14,001 - 14,500	70
14,501 - 15,000	60
15,001 - 15,500	50
15,501 - 16,000	40
16,001 - 16,500	30
16,501 - 17,000	20
17,001 - 17,500	10
17,501 - and over	0

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

History: *L 1984 c 654 art 5 s 58*

9505.2370 RIGHT TO APPEAL.

Subpart 1. **Appeal procedures.** Persons who are recipients of or applying for medical assistance have the right to a fair hearing pursuant to Minnesota Statutes, section 256.045 if they are not informed of and allowed to choose among alternatives available to them as set forth in part 9505.2320, subpart 3, or if the plan of care is not satisfactory. The hearing shall be conducted in accordance with appeal procedures set forth in Minnesota Statutes, section 256.045. If it appears at the hearing that circumstances are different than they were at the time the plan of care was established, the referee may refer the case back to the screening team for reconsideration.

Subp. 2. **Appeal by the physician.** When the treating physician disagrees with the outcome of the screening, the physician shall notify the screening team in order to initiate an appeal on behalf of the individual. The appeal may be withdrawn with the consent of the individual and the treating physician.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2380 COUNTY REPORTS.

The county agency shall submit a report to the Department of Human Services according to a schedule agreed upon by the department and the county agency. The report shall be submitted on forms provided by the commissioner and include the number of persons screened, results of each screening, and the rationale for each screening recommendation. The county agency shall retain the plan of care for persons who are to remain in the community and shall make it available to the department on request. The county agency shall also provide information as requested by the commissioner for ongoing evaluation of the program.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

History: *L 1984 c 654 art 5 s 58*

CONDITIONS FOR MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE REIMBURSEMENT

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 reimbursement to providers of health services for recipients of medical assistance 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 256B.01 to 256B.40; 256B.56 to 256B.71; 256D.01 to 256D.22; and parts 9500.0750 to 9500.1100; 9505.1000 to 9505.1040; and 9505.1750 to 9505.2150.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

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. 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 prior 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.

Subp. 13. **Medicare.** "Medicare" means the health insurance program for the aged and disabled established by title XVIII of the Social Security Act.

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 surgical opinion requirement in parts 9505.5035 to 9505.5100, "physician" shall also mean:

A. 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; or

B. a person who is qualified to render an opinion regarding the surgical procedure as evidenced by his or her certification or eligibility for certification from the appropriate specialty board if, according to the community standard, such certification or eligibility for certification is required of persons performing the surgical procedure in question.

Subp. 15. **Prior authorization.** "Prior authorization" means the written approval and issuance of an authorization number by the department to a provider prior to the provision of a covered health service, as specified in part 9505.5010.

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 or general assistance medical care programs.

Subp. 17. **Recipient.** "Recipient" means a person who is eligible for and receiving benefits from the medical assistance or general assistance medical care programs.

Subp. 18. **Referee.** "Referee" means an individual who conducts fair hearings under Minnesota Statutes, section 256.045 and recommends orders to the commissioner.

Subp. 19. **Working days.** "Working days" means Monday through Friday, excluding state recognized legal holidays.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

9505.5010 PRIOR AUTHORIZATION REQUIREMENT.

Subpart 1. **Provider requirements.** Except as provided in part 9505.5015, a provider shall obtain prior authorization as a condition of reimbursement under the medical assistance and general assistance medical care programs for health services designated under parts 9500.1070 and 9505.5025. Prior authorization shall assure the provider reimbursement for the approved health service only if the service is given during a time the person is a recipient and the provider meets all requirements of the medical assistance or general assistance medical care programs.

Subp. 2. **Expiration of eligibility.** When root canal therapy, removable dental prosthodontics, and other custom fabricated prosthetic, orthotic, or prosthodontic appliance services were started on a recipient who was eligible but whose eligibility for medical assistance or general assistance medical care expired prior to completion of the service, the department shall prorate its allowable reimbursement for the service based on the percentage of the service completed prior to the expiration of the recipient's eligibility.

Subp. 3. **Submission of forms.** The provider shall submit to the department a prior authorization form, DPW-1855, which has been completed according to instructions in the appropriate provider handbook, 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 of failure to comply.** A provider who furnishes health services without complying with the prior authorization requirements of parts 9505.5010 to 9505.5030 shall not be reimbursed. A physician, hospital, or other provider who is denied reimbursement 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 reimbursement is denied.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

9505.5015 RETROACTIVE AUTHORIZATION.

Subpart 1. **Exceptions.** As provided in subparts 2 to 4, medical assistance or general assistance medical care programs reimbursement shall be given for a health service for which the required authorization was requested after the health service was delivered to the recipient.

Subp. 2. **Emergencies.** A health service requiring prior authorization shall be reimbursed without prior authorization in an emergency if the provider submits the prior authorization form, DPW-1855, no later than five working days after providing the initial service and the provider documents the emergency by submitting materials, reports, progress notes, admission histories, or other information which substantiates that the service was necessary to treat the recipient.

Subp. 3. **Retroactive eligibility.** When the health service was provided on or after the date on which the recipient's eligibility began, but before the date the case was opened, a health service requiring prior authorization shall be authorized retroactively if the health service meets the criteria in part 9505.5030, and if an authorization request is submitted to the department within 20 working days of the date the case was opened. The request for retroactive authorization must be submitted to the department in the manner set in part 9505.5010.

Subp. 4. **Medicare denial.** A health service originally billed to Medicare for which reimbursement was denied shall be reimbursed without prior authorization if the service meets the criteria of part 9505.5030 and if the authorization request is submitted to the department along with a copy of the explanation of Medicare benefits (EOMB), within 20 working days of the date of the EOMB.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

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 time limit for its submission, and the provider's right to request an extension when good cause prevents the provider from complying with the time limit. If the department does not receive the requested information or a written request for an extension within 20 working days of the date appearing on the notice which was sent to the provider, the request for prior authorization shall be denied. Upon receipt of notice from the department denying an extension, the provider shall have 20 working days to submit the requested information. If the information is not submitted, the request shall be denied. Extensions shall be granted when circumstances beyond the provider's control prevent his or her compliance. 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 256.991*

History: *10 SR 842*

9505.5025 HEALTH SERVICES PROVIDED OUTSIDE OF MINNESOTA.

Prior authorization is required for health services to be provided outside of Minnesota. 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 256.991*

History: *10 SR 842*

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*

9505.5035 SURGICAL PROCEDURES REQUIRING SECOND OPINION.

Subpart 1. **General requirements.** Except as provided in part 9505.5040, second surgical opinions shall be required for medical assistance and general assistance medical care recipients for inpatient elective surgical procedures according to the list published in the State Register under Minnesota Statutes, section 256B.02, subdivision 8. Publication shall occur annually in the last issue of the State Register for the month of 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 surgical 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 9505.5100 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 256.991*

History: *10 SR 842*

9505.5040 EXEMPTIONS TO SECOND SURGICAL OPINION REQUIREMENTS.

Provided the requirements of part 9505.5095 are met, a second surgical opinion is not required when:

A. The surgical procedure is approved for reimbursement by Medicare.

B. The surgical procedure is a consequence of, or a customary and accepted practice as an incident to, a more major surgical procedure.

C. The procedure is an emergency. For an emergency, the physician shall submit substantiating documentation such as medical reports, progress notes, an admission history, or any other pertinent information necessary to substantiate the characterization of the surgical procedure as an emergency.

D. A visit to another physician to obtain a second opinion requires travel outside the local trade area.

E. The recipient has good cause for not obtaining a second opinion. Good cause refers to circumstances beyond the recipient's control. Examples of good cause include illness of the recipient, illness of a family member requiring the presence of the recipient, weather conditions that prohibit safe travel, or the unavailability of transportation.

F. The surgical procedure is performed before the individual's date of application for MA or GAMC, and retroactive eligibility was extended to cover the period of time during which the surgical procedure was performed.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

9505.5045 CRITERIA TO DETERMINE WHEN SECOND OPINION IS REQUIRED.

The commissioner shall use the criteria in items A to E to determine which surgical procedures shall be subject to the second surgical 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.

E. The surgical procedure has at least a five percent rate of failure to obtain the requisite two physician's approvals, as determined by the Minnesota Medical Assistance Second Surgical Opinion Program or a similar second surgical opinion program.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

9505.5050 THIRD SURGICAL OPINION.

When a second surgical opinion fails to substantiate the initial surgical opinion, a third surgical opinion shall be obtained if the recipient still wants the surgery. No opinion beyond the third opinion shall be considered in meeting the requirements of this part. The cost of an opinion beyond the third opinion shall not be reimbursed under the medical assistance or general assistance medical care programs.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

9505.5055 SECOND OR THIRD OPINION BY A PHYSICIAN.

Subpart 1. **Requirements of recommending physician.** The physician offering to provide the surgical service shall provide to the recipient in need of a second or third surgical opinion, the names of at least two other physicians who are qualified to render a second or third opinion, or the name of an appropriate medical referral resource service, and information about the consequences of failing to obtain a second or third opinion. The physician offering the surgical service shall ensure that the required second opinion and, when required, third opinion, are obtained.

Subp. 2. **Qualifications of physician offering second or third opinions.** The physician offering the surgical service and the physician named to render a second or third opinion or the medical referral resource service shall have no direct shared financial interest or referral relationship resulting in a shared financial gain. The physician who gives a second or third opinion must be a provider.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

9505.5060 PENALTIES.

The penalties for failure to comply with parts 9505.5000 to 9505.5100 shall be imposed in accordance with parts 9505.1750 to 9505.2150 in addition to parts 9500.0960 and 9500.1080.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

9505.5065 REIMBURSEMENT OF COST OF SECOND AND THIRD SURGICAL OPINIONS.

Reimbursement of the cost of second and third surgical opinions under the medical assistance and general assistance medical care programs shall be permitted up to the allowable fee maximums as maintained by the department. When the physician who provides the second or third surgical opinion also performs the surgery, reimbursement for the surgery shall be denied.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

9505.5070 TIME LIMITS; SECOND AND THIRD OPINIONS; SURGERY.

The second surgical opinion shall be obtained within 90 days of the date of the initial opinion. The third opinion, if required, shall be obtained within 45 days of the date of the second opinion. Approved surgery, if not performed within 180 days of the initial opinion, and if still requested by the recipient, shall require repetition of the second surgical opinion process as described in this part.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

9505.5075 PHYSICIAN RESPONSIBILITY.

The physician who provides a second or third opinion shall indicate his or her approval or disapproval of the requested surgical procedure, on a form supplied by the department. The completed form shall contain all the information considered necessary by the commissioner to substantiate the second opinion, shall be personally signed by each physician providing an opinion, shall be attached to a completed and signed prior authorization form, and shall be submitted to the department by the physician who is offering to provide the surgical service.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

9505.5080 FAILURE TO OBTAIN REQUIRED OPINIONS.

Failure to obtain a required second or third surgical opinion shall result in denial of reimbursement for all costs, direct and indirect, associated with the surgery, including costs attributable to other providers and hospitals except for the providers who rendered the second or third opinion. If the physician is unable to secure the required second or third opinions to support the surgical procedure, the second surgical opinion form shall be submitted to the department within 135 days of the date of the first opinion. Failure to comply with this subpart may result in termination of the provider's agreement with the department.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

9505.5085 PROHIBITION OF PAYMENT REQUEST.

A physician, hospital, or other provider who is denied reimbursement because of failure to comply with parts 9505.5035 to 9505.5100 shall not seek payment from the recipient of the service and the recipient shall not be liable for payment for the service for which reimbursement was denied.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

9505.5090 DEPARTMENT RESPONSIBILITY.

If two of the three physicians concur that the requested surgical procedure is appropriate, the department shall certify that the requirements of this part are met and shall assign an authorization number within 30 working days of the department's receipt of the necessary information and forms.

If two of the three physicians concur that the requested surgical procedure is inappropriate, then the department shall deny authorization of reimbursement for the requested surgical procedure. The department shall send the recipient a copy of the notice denying authorization for the surgery and a statement of the recipient's right to appeal as provided in Minnesota Statutes, section 256.045.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

9505.5095 DOCUMENTATION OF EXEMPTIONS.

When the surgical procedure is exempt under part 9505.5040 from the second or third opinion requirement, the provider shall submit documentation to support the basis of the exemption with the claim for payment. In the alternative, approval of the exemption may be requested prior to providing the health service. The request shall be submitted on a form supplied by the department and attached to a prior authorization form. If the requests are approved, an authorization number will be assigned within 30 working days of the department's receipt of the request.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

9505.5100 INDEPENDENT PHYSICIAN EVALUATION.

The commissioner shall have the right to order an independent evaluation by a physician selected by the recipient and approved by the commissioner when the commissioner has reason to believe, based on parts 9505.1750 to 9505.2150, that the requested surgical procedure is not necessary. If the recipient needs assistance locating an appropriate physician, the services of the local county medical society, or any other physician referral resource may be utilized. If the selected physician determines the procedure is not necessary, the commissioner shall deny authorization.

Statutory Authority: *MS s 256.991*

History: *10 SR 842*

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 or on an authorization request under the second surgical opinion program, as established under parts 9505.5020, subpart 1, and 9505.5090;

B. the department has denied a request for prior authorization;

C. the department has denied an authorization request under the second surgical opinion program; or

D. the department has proposed a reduction in service as an alternative to authorization of a proposed service for which prior authorization 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.02, subdivision 8.

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 prior authorization request 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. 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 256.991*

History: *10 SR 842*