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 All persons should be aware that parts 9505.0010 to 9505.0150 of the medical assistance program may be superseded by a change in state or federal law or by a court order prior to the agency having an opportunity to amend these rules.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, sections 256B.02, subdivision 8 and 256B.0625.

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

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

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

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

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

Subp. 26. **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 persons with mental retardation or related conditions.

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 providing reasonable compensation and for the known purpose of creating an applicant's or recipient's eligibility for medical assistance; or

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

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

History: *11 SR 1069; 12 SR 1148; L 1988 c 689 art 2 s 268*

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.055, 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; L 1988 c 689 art 2 s 268*

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.056, subdivision 3, 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.056, subdivision 3, 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.056, subdivision 3.

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

C. One motor vehicle as defined in Minnesota Statutes, section 256B.056, subdivision 3, paragraph (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 grave marker 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; L 1988 c 689 art 2 s 268*

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 December 22, 1986. 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.056, subdivision 4. 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.056, subdivision 4, 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 babysitting, 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 mentally and physically handicapped persons 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 has mental retardation or a related condition 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 cal-

endar 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 252.28 subd 2; 256B.04 subd 2; 256B.092 subd 6; 256B.503*

History: *11 SR 1069; 12 SR 1148; L 1988 c 689 art 2 s 268*

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 parents must be determined according to parts 9550.6200 to 9550.6240 if the responsible spouse or parents provide the information needed to make the determination. The responsible spouse who refuses to provide information needed to determine the financial obligation under subpart 3 is obligated to reimburse the local agency for the full amount of medical assistance paid for health services provided to the recipient. Refusal of responsible parents to provide information needed to determine financial obligation shall result in notification to the parents that the department or county board may institute civil action to recover the required reimbursement under Minnesota Statutes, sections 252.27, subdivision 3, and 256B.14, subdivision 2. The local agency may reduce the amount to be paid on the financial obligation determined under subpart 3 if payment of the financial obligation will cause the responsible spouse undue hardship. Undue hardship to responsible parents is governed by part 9550.6230. In no case shall the financial obligation determined under subpart 3 for the responsible spouse exceed the amount of medical assistance 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. [Repealed, 16 SR 2780]

Subp. 5. **Consideration of parental income.** The income of parents 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, parents shall be responsible for a parental fee determined under part 9550.6220, unless excluded under part 9550.6200, subpart 2.

A. If the child is under age 18 and lives together with the parents, the parents' income and assets must be considered available in determining the child's eligibility, unless the child is under 18 and living together with the parents and the child's eligibility for medical assistance was determined without consideration of the parents' income and assets as:

(1) part of a home– and community–based waiver under Minnesota Statutes, section 256B.092, 256B.49, or 256B.491; or

(2) a disabled child under Minnesota Statutes, section 256B.055, subdivision 12.

The income of parents whose child's eligibility for medical assistance was determined without consideration of the parents' income and assets must be considered in regard to an obligation under parts 9550.6200 to 9550.6240.

B. If a child under age 18 lives together with the parents and is an eligible recipient of supplemental security income, parental income must be considered available in determining the child's eligibility.

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 provide medical support under Minnesota Statutes, section 518.171.

D. 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 parents' income must be considered only in regard to a financial obligation to contribute under parts 9550.6200 to 9550.6240.

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

F. If the child is age 18 or older, is living together with the parents and is determined to be disabled under Minnesota Statutes, section 256B.055, subdivision 7, or is not living together with the parents, and is not claimed as a tax dependent while attending a high school, college, university, postsecondary technical college, or a private business, trade, vocational, or technical college accredited, licensed, or approved under state laws and rules, the parents have no financial obligation.

Subp. 6. **Parental financial obligation.** When the parents have a financial obligation under subpart 5, the parents' 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 parts 9550.6200 to 9550.6240.

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 parents 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 parents and child stop 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 within 30 days of the date of notice of the person's eligibility. Further, the local agency shall notify the responsible spouse 30 days before the effective date of an increase in the obligation to be paid by the responsible spouse. A decrease in the obligation to be paid by the responsible spouse is effective the month following the month of the change in the cost of care or the responsible 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.

At the time eligibility is being determined, notice to the responsible parents shall be given according to part 9550.6220, subpart 1. Review and redetermination of parental fees are governed by part 9550.6228. Notice to the responsible parents of an increase or a decrease in the amount of the parental fee must be given according to part 9550.6229.

Subp. 9. **Appeals.** A responsible spouse 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. Appeals by responsible parents are governed by part 9550.6235.

Subp. 10. **Refusal or failure to pay.** If a responsible spouse 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 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 income and assets is deemed available to the applicant or recipient, the refusal or failure of a responsible spouse 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 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. Refusal or failure of responsible parents to pay the obligated amount is governed by part 9550.6226, subpart 5.

Statutory Authority: *MS s 252.27; 256B.04; 256B.14*

History: *11 SR 1069; L 1987 c 258 s 12; L 1989 c 246 s 2; 16 SR 2780*

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 autho-

rized 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 semiannually 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*

History: *11 SR 1069; 14 SR 2632*

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 department, when the agency or department denies prior authorization, restricts free choice of provider, or reduces services, or reduces, denies, or terminates the person's medical assistance eligibility. The notice must clearly state the proposed action, the reason for the action, the person's right to appeal the proposed action, and the person's right to reapply for eligibility or additional eligibility. The notice must comply with parts 9505.0100 and 9505.0150. 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 9505.2160 to 9505.2245.

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

Subp. 3. **Local agency procedure to ensure access to hearings.** A local agency shall reimburse applicants and recipients for reasonable and necessary expenses of their atten-

dance 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*

MEDICAL ASSISTANCE PAYMENTS

9505.0170 APPLICABILITY.

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

Parts 9505.0170 to 9505.0475 must be read in conjunction with title XIX of the Social Security Act as amended through October 17, 1986; Code of Federal Regulations, title 42; and Minnesota Statutes, including chapters 256 and 256B; and parts 9505.5000 to 9505.5105. Unless otherwise specified, citations of Code of Federal Regulations, title 42, refer to the code amended as of October 1, 1985.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0175 DEFINITIONS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subp. 18. **Licensed consulting psychologist.** "Licensed consulting psychologist" means a person licensed to provide health services under Minnesota Statutes, section 148.91, subdivision 4.

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

Subp. 20. **Licensed psychologist.** "Licensed psychologist" means a person licensed to provide health services under Minnesota Statutes, section 148.91, subdivision 5.

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

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

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

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

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

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

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

C. is a preventive health service under part 9505.0355.

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

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

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

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

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

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

Subp. 32. **Performance agreement.** "Performance agreement" means a written agreement between the department and a provider that states the provider's contractual obligations for the sale and repair of medical equipment and medical supplies eligible for medical assistance payment. An example of a performance agreement is an agreement between the department and a provider of nondurable medical supplies or durable medical equipment as specified in part 9505.0310, subpart 3, items A and B.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History: *12 SR 624; L 1988 c 689 art 2 s 268; 13 SR 1439; 14 SR 8; 17 SR 1454; 17 SR 2042*

9505.0180 SURVEILLANCE AND UTILIZATION CONTROL PROGRAM.

Subpart 1. [Repealed, 15 SR 2563]

Subp. 2. **Duty to implement.** The department shall carry out a program of a surveillance and utilization review under parts 9505.2160 to 9505.2245 and Code of Federal Regulations, title 42, part 455, and a program of utilization control under Code of Federal Regulations, title 42, part 456. These programs together constitute the surveillance and utilization control program.

Subp. 3. **Surveillance and utilization review.** The surveillance and utilization review program must have a post payment review process to ensure compliance with the medical assistance program and to monitor both the use of health services by recipients and the delivery of health services by providers. The process must comply with parts 9505.2160 to 9505.2245.

Subp. 4. **Utilization control.** The department shall administer and monitor a program of utilization control to review the need for, and the quality and timeliness of, health services provided in a hospital, long–term care facility, or institution for the treatment of mental diseases. A facility certified for participation in the medical assistance program must comply with the requirements of Code of Federal Regulations, title 42, part 456 for utilization control.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 15 SR 2563*

9505.0185 PROFESSIONAL SERVICES ADVISORY COMMITTEE.

Subpart 1. **Appointees.** The commissioner shall appoint a professional services advisory committee comprised of persons who are licensed or certified in their professions under state law and who are familiar with the health service needs of low income population groups. The committee must have at least 15 members who are representative of the types of covered services. In appointing committee members, the commissioner shall:

A. publish a notice in the State Register to request applications from persons licensed or certified in a health service profession;

B. consider all individuals who respond to the notice in item A or are recommended by a provider or a professional organization of providers;

C. ensure that when the committee is reviewing a particular health service, at least one member of the committee is a provider or representative of the health service.

Subp. 2. **Condition of appointment.** As a condition of appointment, an individual named to serve on the committee shall sign a contract with the department. The contract shall conform to the requirements of Minnesota Statutes, section 16B.17, and shall provide for periods and hours of expected service by a committee member, the fee to be paid for service, and the grounds and notice required to cancel the contract.

Subp. 3. **Committee organization.** The chairperson of the committee shall be appointed by the commissioner. The committee may establish subcommittees of any of its members and may delegate to a member or a subcommittee any of its duties.

Subp. 4. **Committee meetings.** The committee shall meet at the call of the department. The chairperson of the committee may call additional meetings including telephone conferences as necessary to carry out the duties in subparts 5 and 6.

Subp. 5. **Duty to advise commissioner.** When requested by the commissioner, the committee shall review and advise the commissioner about the matters in items A to H:

A. payments of medical assistance funds for covered services;

B. requests for prior authorization;

C. billings for covered services that are not clearly within the service limits in parts 9505.0170 to 9505.0475;

D. purchase requests;

E. payments proposed for unlisted or unpriced procedures;

F. utilization procedures;

G. determinations of medical necessity; and

H. standards for determining the necessity of health services.

Subp. 6. **Other duties.** The committee may initiate discussions, and make recommendations to the commissioner, about policies related to health services eligible for medical assistance payments under parts 9505.0170 to 9505.0475 and about matters related to the surveillance and utilization review program under parts 9505.2160 to 9505.2245.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0190 RECIPIENT CHOICE OF PROVIDER.

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0195 PROVIDER PARTICIPATION.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subp. 6. **Consequences of failure to comply.** A provider who fails to comply with the terms of participation in the provider agreement or parts 9505.0170 to 9505.0475 or 9505.2160 to 9505.2245 is subject to monetary recovery, sanctions, or civil or criminal action as provided in parts 9505.1750 to 9505.2150. Unless otherwise provided by law, no provider of health services shall be declared ineligible without prior notice and an opportunity for a hearing under Minnesota Statutes, chapter 14, on the commissioner's proposed action.

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

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

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

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

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

C. obtain department approval as in subpart 3; and

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

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0200 COMPETITIVE BIDDING.

Under certain conditions, the commissioner shall seek competitive bids for items designated in Minnesota Statutes, section 256B.04, subdivision 14, and for durable medical

equipment. Competitive bids are required if the item of durable medical equipment is available from more than one manufacturer and at least one of the following conditions exists:

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0205 PROVIDER RECORDS.

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0210 COVERED SERVICES; GENERAL REQUIREMENTS.

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

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

(1) be medically necessary;

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

(3) meet quality and timeliness standards;

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

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

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

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624; 17 SR 1279*

9505.0215 COVERED SERVICES; OUT–OF–STATE PROVIDERS.

A health service provided to a recipient by an out–of–state provider is eligible for medical assistance payment if the service meets the requirements of items A, B, and C. For purposes of this part, "out–of–state provider" means a provider who is located outside of Minnesota and outside of the recipient's local trade area.

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

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

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

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 17 SR 3047*

9505.0220 HEALTH SERVICES NOT COVERED BY MEDICAL ASSISTANCE.

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

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

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

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

D. autopsies;

E. missed or canceled appointments;

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

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

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

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

J. separate charges for the preparation of bills;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

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

9505.0221 PAYMENT LIMITATION; PARTIES AFFILIATED WITH A PROVIDER.

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

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 17 SR 2042*

9505.0225 REQUEST TO RECIPIENT TO PAY.

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

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0235 ABORTION SERVICES.

Subpart 1. **Definition.** For purposes of this part, "abortion related services" means services provided in connection with an elective abortion except those services which would otherwise be provided in the course of a pregnancy. Examples of abortion related services include hospitalization when the abortion is performed in an inpatient setting, the use of a

facility when the abortion is performed in an outpatient setting, counseling about the abortion, general and local anesthesia provided in connection with the abortion, and antibiotics provided directly after the abortion.

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

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

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

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

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0240 AMBULATORY SURGICAL CENTERS.

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

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

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

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

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

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

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

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

F. Blood, blood plasma, and platelets.

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0245 CHIROPRACTIC SERVICES.

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

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

B. "Chiropractor" means a person licensed under Minnesota Statutes, sections 148.01 to 148.101.

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

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

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

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

A. laboratory service;

B. diathermy;

C. vitamins;

D. ultrasound treatment;

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

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

G. X–rays not listed in subpart 2.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0250 CLINIC SERVICES.

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

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

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

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

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0255 COMMUNITY HEALTH CLINIC SERVICES.

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

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

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

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

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

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

A. physician services under part 9505.0345;

B. preventive health services under part 9505.0355;

C. family planning services under part 9505.0280;

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

E. dental services under part 9505.0270; and

F. prenatal care services under part 9505.0353.

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

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

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

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

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

Statutory Authority: *MS s 256B.04*

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

9505.0260 COMMUNITY MENTAL HEALTH CENTER SERVICES.

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

A. "Community mental health center service" means services by a community mental health center that provides mental health services specified in part 9505.0323, subpart 2, and physician services under part 9505.0345, including the determination of a need for prescribed drugs and the evaluation of prescribed drugs.

B. Notwithstanding the definition of "supervision" in part 9505.0175, subpart 46, "supervision" means "clinical supervision" as defined in part 9505.0323, subpart 1, item D.

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

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

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

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

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

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

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

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

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

H. provide mental health services specified in Minnesota Statutes, sections 245.461 to 245.4888;

I. have a sliding fee schedule; and

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

Subp. 3. **Payment limitation; community mental health center services.** Medical assistance payment limitations applicable to community mental health center services include the payment limitations in part 9505.0323.

Subp. 4. [Repealed, 17 SR 1454]

Subp. 5. **Excluded services.** The services listed in part 9505.0323, subpart 27, are not eligible for medical assistance payment as community mental health services.

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

History: *14 SR 8; 17 SR 1454*

9505.0270 DENTAL SERVICES.

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

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

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

C. "Rebase" refers to totally replacing the denture base material that rests on the recipient's denture foundation area.

D. "Reline" refers to resurfacing the portion of the denture base that rests on the recipient's denture foundation area.

E. "Removable prosthesis" means a removable structure that is prescribed by a dentist to replace a complete or partial set of teeth and made according to the dentist's direction.

Subp. 2. **Eligible dental services.** The medical assistance program shall pay for a recipient's dental service that is medically necessary.

Subp. 3. **Payment limitations; general.** Payment for dental services is limited to services listed in items A to I.

A. One oral hygiene instruction per recipient.

B. One reline or rebase every three years.

C. One topical fluoride treatment every six months for a recipient 16 years of age or under unless prior authorization is obtained.

D. One full mouth or panoramic X–ray survey every three years unless an additional survey is medically necessary and prior authorization is obtained.

E. One dental examination every six months unless an emergency requires medically necessary dental service.

F. One prophylaxis every six months.

G. One bitewing series of no more than four X–rays and no more than six periapical X–rays every 12 months unless a bitewing or periapical X–ray is medically necessary because of an emergency.

H. Palliative treatment for an emergent root canal problem.

I. One application of sealants to permanent first and second molars only and one reapplication of sealants to permanent first and second molars five years after the first application. Only a recipient 16 years of age or under is eligible for the application or reapplication of a sealant.

Subp. 4. **Criteria for prior authorization of removable prostheses.** All removable prostheses require prior authorization to be eligible for medical assistance payments. The criteria for prior authorization of a removable prosthesis are as specified in items A to C. A request for prior authorization of a removable prosthesis must be approved or denied no later than 30 days after the department has received information necessary to determine whether the request meets a criterion in one of the items A to C.

A. Purchase or replacement of a removable prosthesis is limited to one time every five years for a recipient, except as in items B and C.

B. Replacement of a removable prosthesis in excess of the limit in item A is eligible for payment if the replacement is necessary because the removable prosthesis was misplaced, stolen, or damaged due to circumstances beyond the recipient's control. The recipient's degree of physical and mental impairment shall be considered in determining whether the circumstances were beyond the recipient's control.

C. Replacement of a partial prosthesis, in excess of the limits in item A, is eligible for payment if the existing prosthesis cannot be modified and one of the following subitems applies.

(1) The recipient is missing one or more of the upper or lower six front teeth which are in addition to those for which the prosthesis was designed.

(2) The recipient has less than four upper and four lower back teeth that meet and are in biting function unless the missing teeth are the permanent teeth and the recipient has only bicuspid occlusion.

(3) The recipient has lost one of the teeth used to anchor the partial prosthesis. In this event, prior authorization for replacement of the partial prosthesis will not be approved if the anchoring teeth are not expected to support the prosthesis for at least one year and if the X–rays of the area show sufficient bone loss so that the anchoring teeth will not sustain the denture.

Subp. 5. **Criteria for prior authorization of root canal treatment.** Root canal treatment after palliative treatment in subpart 3, item H, requires prior authorization to be eligible for medical assistance payment. Prior authorization of a root canal treatment shall be determined by:

A. the adequacy of bone support for the tooth to be treated;

B. the functional and aesthetic importance of the tooth;

C. the condition and restorability of the coronal portion of the tooth; and

D. the positional relationship of any teeth missing within the same dental arch.

Subp. 6. **Other services requiring prior authorization.** The dental services in items A to G are eligible for payment under the medical assistance program only if they have received prior authorization:

A. hospitalization for dental services;

B. periodontics;

C. root canal treatment subsequent to palliative treatment in subpart 3, item H;

D. orthodontics, except for space maintainers for second deciduous molars;

E. surgical services except emergencies and alveolectomies;

F. services in excess of the limits in subpart 3; and

G. removal of impacted teeth.

A request for prior authorization of one of the services listed in items A to G must be approved or denied no later than 30 days after the department has received the information necessary to document the request.

Subp. 7. **Criteria for prior authorization of orthodontic treatment.** An orthodontic treatment is eligible for medical assistance payment only if it has received prior authoriza-

tion. The criteria for prior authorization of orthodontic treatment are as specified in items A to E:

A. disfigurement of the recipient's facial appearance including protrusion of upper or lower jaws or teeth;

B. spacing between adjacent teeth that may interfere with biting function;

C. overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when the person bites;

D. positioning of jaws or teeth to the extent that the chewing or biting function is impaired; or

E. overall orthodontic problem which is based on a comparable assessment of items A to D.

Subp. 8. **Payment limitation; removable prosthesis.** The payment rate for a removable prosthesis that received prior authorization under subpart 4 shall include payment for instruction in the use and care of the prosthesis and any adjustment necessary during the six months immediately following the provision of the prosthesis to achieve a proper fit. The dentist shall document the instruction and the necessary adjustments, if any, in the recipient's dental record.

Subp. 9. **Payment limitation; more than one recipient on same day in same long–term care facility.** When a dental service is provided by the same provider on the same day to two or more recipients who reside in the same long–term care facility, payment for the provider's visit to the first recipient shall be according to part 9505.0445, item E, for the procedure code for the visit. The provider's visit on the same day to other recipients within the same long–term care facility must be billed with the multiple visit code established by the department. This subpart shall not apply to a provider's visit to provide an emergency service on the same day within the same long–term care facility if the emergency service could not have been scheduled consecutively with another recipient visit. If the provider visits other recipients in the same facility on the same day after providing an emergency service, the provider's visits must be billed with the multiple visit code.

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

A. full mouth or panoramic X–rays for a recipient under eight years of age unless prior authorization is given, or in the case of an emergency;

B. bases or pulp caps;

C. a local anesthetic that is billed as a separate procedure;

D. hygiene aids, including toothbrushes;

E. medication dispensed by a dentist that a recipient is able to obtain from a pharmacy;

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

G. periapical X–rays, if done at the same time as a panoramic or full mouth X–ray survey unless prior authorization is given;

H. prosthesis cleaning;

I. unilateral partial prosthesis involving posterior teeth;

J. individual crown made of a substance other than stainless steel and prefabricated acrylic;

K. fixed prosthodontics;

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0275 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT.

Subpart 1. **Definition.** "Early and periodic screening, diagnosis, and treatment service" means a service provided to a recipient under age 21 to identify a potentially handicapping

condition and to provide diagnosis and treatment for a condition identified according to the requirements of the Code of Federal Regulations, title 42, section 441.55 and parts 9505.1693 to 9505.1748.

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

Statutory Authority: *MS s 256B.04 subds 2,4,12; 256B.0625 subd 14*

History: *12 SR 624; 13 SR 1150*

9505.0280 FAMILY PLANNING SERVICES.

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

A. "Family planning service" means a health service or family planning supply concerned with the voluntary planning of the conception and bearing of children and related to a recipient's condition of fertility, or to the treatment of a sexually transmitted disease or other genital infection.

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

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

A. the recipient requested the service;

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

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

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0285 HEALTH CARE PREPAYMENT PLANS OR PREPAID HEALTH PLANS.

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

A. have a contract with the department; and

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0287 HEARING AID SERVICES.

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

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

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

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

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

E. "Hearing aid services provider" means a person who has a permit from the commissioner of health as a seller of hearing instruments and, when applicable, meets the specific state licensure and registration requirements of the commissioner of health for the hearing aid services the person provides. A hearing aid services provider who is not an audiologist or an otolaryngologist must not perform an audiologic evaluation.

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

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

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

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

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

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

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

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

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

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

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

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

Subp. 5. **Hearing aid services provider payment.** A hearing aid services provider must receive one payment for fitting a new hearing aid for a recipient plus providing at least

three batteries of the type necessary to operate the hearing aid. A hearing aid services provider must not request payment until after the hearing aid is dispensed. The payment also covers the following hearing aid services during the hearing aid warranty period:

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

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

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

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

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

A. a request by the recipient;

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

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

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

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

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

B. hearing aid accessories.

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

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

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

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

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

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

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

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

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

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

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

H. canal hearing aids;

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

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

Statutory Authority: *MS s 256B.04*

History: *17 SR 2042*

9505.0290 HOME HEALTH AGENCY SERVICES.

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

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

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

A. Nursing service as defined by Minnesota Statutes, section 148.171, clause (3).

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

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

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 15 SR 2404*

9505.0295 HOME HEALTH SERVICES.

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

A. ordered by a physician; and

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

C. provided to the recipient at his or her residence that is a place other than a hospital or long–term care facility except as in part 9505.0360, or unless the home health service in an intermediate care facility is for an episode of acute illness and is not a required standard for care, safety, and sanitation in an intermediate care facility under Code of Federal Regulations, title 42, part 442, subpart F or G.

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

A. nursing services under part 9505.0290;

B. private duty nursing services under part 9505.0360;

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

D. personal care services under part 9505.0335;

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

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

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

H. oxygen ordered in writing by a physician.

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

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

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

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

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

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

(3) Home health services may be provided for a ventilator dependent recipient if the screening team determines the recipient's health care needs can be provided in the recipient's residence and the cost of home health services is less than the projected monthly cost of services provided by the least expensive hospital in the recipient's local trade area that is staffed and equipped to provide the recipient's necessary care. The recipient's physician in

consultation with the staff of the hospital shall determine whether the hospital is staffed and equipped to provide the recipient's necessary care. The hospital's projected monthly cost must be computed by multiplying the projected monthly charges that the hospital would bill to medical assistance for services to the recipient by the hospital's cost to charge ratio as determined by a medical assistance settlement made under title XIX of the Social Security Act.

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

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 13 SR 1448; 15 SR 2404*

9505.0297 HOSPICE CARE SERVICES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

M. "Social worker" means a person who has at least a bachelor's degree in social work from a program accredited or approved by the Council of Social Work Education and who complies with Minnesota Statutes, sections 148B.21 to 148B.28.

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

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

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

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

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

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

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

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

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

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

A. designation of the hospice that will provide care;

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

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

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

E. the recipient's signature.

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

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

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

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

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

(1) provided by the designated hospice;

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

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

C. Personal care services, under part 9505.0335.

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

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

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

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

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

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

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

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

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

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

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

B. the date the change is to be effective.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Statutory Authority: *MS s 256B.02 subd 8 cl (20)*

History: *13 SR 1861*

9505.0300 INPATIENT HOSPITAL SERVICES.

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

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

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

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

timely review of the medical necessity of admissions, extended duration stay, and health services rendered.

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

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

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

Subp. 5. **Excluded services.** Inpatient hospital admission and services are not eligible for payment under the medical assistance program if they are not medically necessary under parts 9505.0500 to 9505.0540; if they are for alcohol detoxification that is not medically necessary to treat an emergency; if they are denied a required prior authorization; or if they are surgical procedures requiring a second surgical opinion that has failed to be approved by a second or third surgical opinion.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0305 LABORATORY AND X-RAY SERVICES.

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

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

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0310 MEDICAL SUPPLIES AND EQUIPMENT.

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

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

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

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

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

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

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

Payment for durable medical equipment that is not for the continuous care and exclusive use of the recipient is included within the payment rate made to the hospital under parts 9500.1090 to 9500.1155 and to the long–term care facility under part 9549.0060.

B. In addition to the types of equipment and supplies specified in part 9549.0040, subpart 5, item U, the following durable medical equipment, prosthetics, and medical supplies are considered to be included in the payment to a hospital or long–term care facility and are not eligible for medical assistance payment on a separate claim for payment.

(1) Equipment of the type required under parts 4655.0090 to 4655.9900.

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

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

(4) Emergency oxygen.

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

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

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

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

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

C. maintenance of durable medical equipment.

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

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

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

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

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

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

E. dental hygiene supplies and equipment; and

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0315 MEDICAL TRANSPORTATION.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. airport surcharge; and

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

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

A. The provider must be licensed under Minnesota Statutes, sections 144.802 and 144.804 as an advanced life support, basic life support, or scheduled ambulance service.

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

C. The medical necessity of the ambulance service for a recipient must be documented by the state report required under Minnesota Statutes, section 144.807.

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

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

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

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

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

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

D. One way mileage for special transportation within the recipient's local trade area must not exceed 20 miles for a trip originating in the seven county metropolitan area or

40 miles for a trip originating outside of the seven county metropolitan area if a similar health service is available within the mileage limitation. The seven county metropolitan area consists of the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington.

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624; L 1987 c 209 s 39; L 1988 c 689 art 2 s 268*

9505.0320 NURSE MIDWIFE SERVICES.

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

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

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

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0322 MENTAL HEALTH CASE MANAGEMENT SERVICES.

Subpart 1. **Definitions.** The terms used in this part have the meanings given them in items A to G and in part 9505.0323, subpart 1.

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

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

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

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

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

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

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

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

Subp. 3. **Required contents of a diagnostic assessment.** To be eligible for medical assistance payment, the diagnostic assessment required for a determination of a recipient's eligibility to receive mental health case management services must comply with the requirements of part 9505.0323, subpart 4. Additionally, the diagnostic assessment must identify the needs that must be addressed in the recipient's individual treatment plan if the recipient is determined to have a serious and persistent mental illness or a severe emotional disturbance.

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

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

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

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

(2) a child for reasons related to the child's emotional disturbance who meets a criterion specified in part 9505.0323, subpart 20; or

(3) the parent of a child;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subp. 11. **Documentation of services.** To obtain medical assistance payment for case management services, the case manager must document the recipient's case management services according to the requirements of part 9505.0323, subpart 26, and parts 9505.2175 and 9505.2180. Additionally, if a case manager who provides other mental health services eligible for medical assistance payment to a recipient who receives case management services from the case manager and intersperses the recipient's case management service and the other mental health services eligible for medical assistance payment within the same session, the case manager must clearly document in the recipient's record the intervals in which each service was provided.

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

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

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

A. Recipients who are receiving case management services through the Veterans Administration are not eligible for case management services under parts 9520.0900 to

9520.0926 and this part while they are receiving case management through the Veterans Administration.

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

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

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

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

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

History: *17 SR 1454*

9505.0323 MENTAL HEALTH SERVICES.

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

A. "Biofeedback" means a service designed to assist a client to regulate a bodily function controlled by the autonomic nervous system, such as heartbeat or blood pressure, by using an instrument to monitor the function and signal the changes in the function.

B. "Case management services" means the activities specified in Minnesota Statutes, section 245.462, subdivision 3, in the case of an adult, or section 245.4871, subdivision 3, in the case of a child.

C. "Case manager" has the meaning given in Minnesota Statutes, section 245.462, subdivision 4, for services to an adult, or section 245.4871, subdivision 4, for services to a child.

D. "Child" means a person under 18 years of age.

E. "Client" means a recipient who is determined to be mentally ill or emotionally disturbed as specified in subpart 2.

F. "Clinical supervision" means the process of control and direction of a client's mental health services by which a mental health professional who is a provider accepts full professional responsibility for the supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the work of the supervisee. The process must meet the conditions in subitems (1) to (3).

(1) The provider must be present and available on the premises more than 50 percent of the time in a five working day period during which the supervisee is providing a mental health service.

(2) The diagnosis and the client's individual treatment plan or a change in the diagnosis or individual treatment plan must be made by or reviewed, approved, and signed by the provider.

(3) Every 30 days the supervisor must review and sign the record of the client's care for all activities in the preceding 30–day period.

G. "Day treatment" or "day treatment program" means a structured program of treatment and care provided to persons in:

(1) an outpatient hospital accredited by the Joint Commission on the Accreditation of Hospitals and licensed under Minnesota Statutes, sections 144.50 to 144.55;

(2) a community mental health center under part 9505.0260; or

(3) an entity that is under contract with the county to operate a program that meets the requirements of Minnesota Statutes, sections 245.4712, subdivision 2, and 245.4884, subdivision 2, and parts 9505.0170 to 9505.0475.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided by a multidisciplinary staff. The services are aimed at stabilizing the client's mental health status, providing mental health services, and developing and improving the client's independent living and socialization skills. The goal of day treatment is to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. Day treatment services are not a part of inpatient or residential treatment services. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services.

H. "Diagnostic assessment" means a written evaluation by a mental health professional of a person's:

(1) current life situation and sources of stress and the reasons for referral;

(2) history of the person's current mental health problem, important developmental incidents, strengths, and vulnerabilities;

(3) current functioning and symptoms;

(4) diagnosis and determination of whether the person has a serious and persistent mental illness or severe emotional disturbance; and

(5) needed mental health services.

I. "Emotional disturbance" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 15.

J. "Explanation of findings" means analysis and explanation of a diagnostic assessment, psychological testing, client's treatment program, consultation with special mental health consultants as required under parts 9520.0900 to 9520.0926, or other accumulated data and recommendations to the client's family, primary caregiver, or other responsible persons. Examples of responsible persons are a qualified mental retardation professional; a case manager; providers; a child protection worker; a vulnerable adult worker; the recipient's guardian, if any; and representatives of a local education agency, school, or community corrections agency that has a responsibility to provide services for the recipient.

K. "Family psychotherapy" means psychotherapy as specified in subpart 13 that is designed for the client and one or more persons who are related to the client by blood, marriage, or adoption, or who are the client's foster parents, the client's primary caregiver, or significant other and whose participation is necessary to accomplish the client's treatment goals. For purposes of this item, "persons whose participation is necessary to accomplish the client's treatment goals" does not include shift or facility staff members at the client's residence.

L. "Group psychotherapy" means psychotherapy conducted by a mental health professional for more than three but not more than eight persons or psychotherapy co–conducted by two mental health professionals for at least nine but not more than 12 persons who because of the nature of their emotional, behavioral, or social dysfunctions can derive mutual benefit from interaction in a group setting.

M. "Hour" means a 60–minute session of mental health service other than a diagnostic assessment. At least 45 minutes of the period must be spent in face–to–face contact with the client. The other 15 minutes may be spent in client–related activities. Examples of

client–related activities are scheduling, maintaining clinical records, consulting with others about the client's mental health status, preparing reports, receiving the clinical supervision directly related to the client's psychotherapy session, and revising the client's individual treatment plan. If the period of service is longer or shorter than one hour, up to one–fourth of the time may be spent in client–related activities.

N. "Hypnotherapy" means psychotherapeutic treatment through hypnosis induced by a mental health professional trained in hypnotherapy.

O. "Individual psychotherapy" means psychotherapy designed for one client. For purposes of this part, hypnotherapy and biofeedback are individual psychotherapy.

P. "Individual treatment plan" has the meaning given it in Minnesota Statutes, section 245.462, subdivision 14, for an adult, or section 245.4871, subdivision 21, for a child.

Q. "Mental health services" means the services defined in items A, B, F, G, H, J, K, L, N, O, S, U, W, X, and Y and subpart 30, home–based mental health services as specified in part 9505.0324, and mental health case management services as specified in part 9505.0322.

R. "Mental illness" has the meaning given it in Minnesota Statutes, section 245.462, subdivision 20.

S. "Multiple family group psychotherapy" means psychotherapy as specified in subpart 28.

T. "Neurological examination" means an examination of a person's nervous system by or under the supervision of a physician skilled in the diagnosis and treatment of disorders of the nervous system.

U. "Partial hospitalization" or "partial hospitalization program" means a time–limited, structured program of psychotherapy and other therapeutic services provided in an outpatient hospital licensed under Minnesota Statutes, sections 144.50 to 144.55 and accredited by the Joint Committee on Accreditation of Hospitals. Partial hospitalization is an appropriate alternative or adjunct to inpatient hospitalization for a client who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission as specified in part 9505.0540, subpart 1, and who has the family and community resources necessary and appropriate to support the client's residence in the community. Partial hospitalization consists of multiple and intensive therapeutic services provided by a multidisciplinary staff to treat the client's mental illness. The goal of partial hospitalization is to resolve or stabilize an acute episode of mental illness. Examples of services provided in partial hospitalization are individual, group, and family psychotherapy services.

V. "Primary caregiver" means a person who has primary responsibility for providing the recipient with food, clothing, shelter, direction, guidance, and nurturance. A primary caregiver is someone other than the recipient's parent or a shift or facility staff member in a facility or institution where the recipient is residing or receiving a health service. An example of a primary caregiver is a recipient's relative who is not the recipient's parent and with whom the recipient lives.

W. "Psychological testing" means the use of tests or other psychometric instruments to determine the status of the recipient's mental, intellectual, and emotional functioning. A face–to–face interview sufficient to validate the psychological test is a required component of psychological testing.

X. "Psychotherapy" means a health service for the face–to–face treatment of a client or clients with mental illness through the psychological, psychiatric, or interpersonal method most appropriate to the needs of the client and in conformity with prevailing community standards of mental health practice. The treatment is a planned structured program or other intervention based on a diagnosis of mental illness resulting from a diagnostic assessment and is directed to accomplish measurable goals and objectives specified in the client's individual treatment plan. Individual, family, and group psychotherapy are the types of psychotherapy. Examples of psychotherapy goals and objectives are relieving subjective distress, alleviating specific existing symptoms, modifying specific patterns of disturbed behavior, stabilizing the level of functioning attainable by the client, and enhancing the ability of the client to adapt to and cope with specific internal and external stressors.

Y. "Psychotherapy session" means a planned and structured face–to–face treatment episode between the vendor or provider of psychotherapy and one or more individuals.

A psychotherapy session may consist of individual psychotherapy, family psychotherapy, or group psychotherapy.

Z. "Special mental health consultant" means the mental health practitioner or professional defined in Minnesota Statutes, section 245.4871, subdivision 33a.

Subp. 2. **Determination of mental illness or emotional disturbance.** Except as provided in subpart 3, a diagnostic assessment that results in a diagnosis of mental illness or emotional disturbance is the criterion used to determine a recipient's eligibility for mental health services under this part. The diagnostic assessment of a recipient who is receiving mental health services other than case management services under parts 9505.0322 and 9520.0900 to 9520.0926 must be reviewed once every 12 months to determine whether the recipient continues to have a diagnosis of mental illness or emotional disturbance. Unless a recipient's mental health condition has changed markedly since the recipient's most recent diagnostic assessment, only updating is necessary. If the recipient's mental health condition has changed markedly, a new diagnostic assessment must be completed. For purposes of this subpart, "updating" means a written summary by a mental health professional of the recipient's current mental health status and service needs.

Subp. 3. **Payment limitation; recipient who is mentally ill.** Medical assistance payment is available for a diagnostic assessment, an explanation of findings, psychological testing, and one psychotherapy session before completion of the diagnostic assessment if the person is a recipient and the provider complies with the requirements of this part. Other mental health services to a recipient are eligible for medical assistance payment only if the recipient has a mental illness as determined through a diagnostic assessment.

Subp. 4. **Eligibility for payment; diagnostic assessment.** To be eligible for medical assistance payment, a diagnostic assessment must be conducted by a provider who is a mental health professional. Additionally, to be eligible for medical assistance payment, a diagnostic assessment must comply with the requirements in items A to L.

A. A provider may receive medical assistance reimbursement for only one diagnostic assessment per calendar year per recipient unless:

(1) the recipient's mental health status has changed markedly since the recipient's most recent diagnostic assessment by the same provider; or

(2) the provider conducting the diagnostic assessment who has referred the recipient to a psychiatrist for a psychiatric consultation needs to revise the recipient's diagnostic assessment as a result of the report of the psychiatric consultation. In the event of the recipient's referral to a psychiatrist, the provider referring the recipient shall document the reason for the referral in the recipient's record.

B. Medical assistance will not pay for more than four diagnostic assessments per recipient per calendar year.

C. Except as set forth in subparts 5 and 6, medical assistance payment for a diagnostic assessment is limited to two hours per assessment.

D. A recipient may choose another provider of a diagnostic assessment but the limit in item B shall apply.

E. The limits in this subpart apply whether all components of the diagnostic assessment are carried out by one mental health professional, by more than one mental health professional, or in a multiple provider setting. Examples of a multiple provider setting are outpatient hospitals, group practices, and community mental health centers.

F. The activities necessary to complete a recipient's diagnostic assessment may be spread out over more than one day but the billing for a diagnostic assessment must be dated as of the date the diagnostic assessment is completed.

G. A diagnostic assessment carried out by a mental health professional in a multiple provider setting must be available to other mental health professionals, or other providers in the same setting who need the diagnostic assessment to provide mental health services to the recipient. Additional diagnostic assessments of the recipient in the same multiple provider setting are subject to the limit specified in item A.

H. Medical assistance does not pay for a recipient's diagnostic assessment performed on a day during which a recipient participates in a psychotherapy session unless the

psychotherapy session is necessary because of an emergency or unless the psychotherapy session occurs as specified in subpart 3.

I. The mental health professional conducting the diagnostic assessment must:

(1) address the components in subpart 1, item H;

(2) conduct a face–to–face interview with the recipient;

(3) conduct a mental status examination which describes the recipient's appearance, general behavior, motor activity, speech, alertness, mood, cognitive functioning, and attitude toward his or her symptoms;

(4) review pertinent records;

(5) consider the recipient's need for referral for psychological testing, psychiatric consultation, a neurological examination, a physical examination, a determination of the need for prescribed drugs, the evaluation of the effectiveness of prescribed drugs, and a chemical dependency assessment as specified in part 9530.6615. The mental health professional must refer the recipient to a psychiatrist for a psychiatric consultation or medication evaluation if:

(a) the recipient has not had a psychiatric consultation or medication evaluation within the 180 days before the current diagnostic assessment; and

(b) in the case of an adult, the recipient is given a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder as specified in the definition of serious and persistent mental illness in Minnesota Statutes, section 245.462, subdivision 20, paragraph (c), clause (3)(i); or

(c) in the case of a child, the recipient is given a diagnosis of mood disorder or obsessive compulsive disorder or, as specified in the definition of severe emotional disturbance in Minnesota Statutes, section 245.4871, subdivision 6, clause (3)(i) or (ii), a diagnosis of psychosis or clinical depression, risk of harming self or others as a result of emotional disturbance; or

(d) in the case of a child, the recipient's treatment plan may include the use of medication or residential treatment.

The mental health professional must refer the recipient who is a child and who is given a diagnosis of attention deficit hyperactivity disorder or undifferentiated attention deficit disorder as specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM–IIIR), current edition, to a psychiatrist or a physician who is competent to prescribe and monitor the effects of psychoactive medication for a pediatric population with attention deficit hyperactivity disorder or undifferentiated attention deficit disorder.

The mental health professional may complete the diagnostic assessment, initiate treatment, and bill medical assistance for the mental health services before the consultation or evaluation is completed. If, upon review of the report of the psychiatrist or, in the case of a child with attention deficit hyperactivity disorder or undifferentiated attention deficit disorder, the report of the psychiatrist or physician, the mental health professional believes the diagnostic assessment needs to be updated to include the recommendations of the psychiatrist or physician, the updating of the diagnostic assessment will be eligible for medical assistance payment. The mental health professional conducting the diagnostic assessment for an adult or a child must specify, in the recipient's record, the consideration of biological factors which may be contributing to the recipient's mental illness or emotional disturbance and the recipient's referral or the reason why the referral was not made.

The Diagnostic and Statistical Manual of Mental Disorders is published by the American Psychiatric Association, 1400 K Street N.W., Washington, D.C. 20005. The DSM–IIIR is incorporated by reference, available through the Minitex interlibrary loan system, and is subject to frequent change.

(6) refer the recipient for medically necessary services that are outside the scope of practice of the mental health professional;

(7) if clinically appropriate and if authorized as specified in subpart 19 or 20, contact the recipient's family or primary caregiver or document the reason the contact was not made; and

(8) record the results of the diagnostic assessment in the recipient's record.

J. Medical assistance will only pay for a neurological examination, psychiatric consultation, physical examination, determination of the need for prescribed drugs, evaluation of the effectiveness of prescribed drugs, and psychological testing carried out in conjunction with a diagnostic assessment if they are billed as separate procedures, distinct from a diagnostic assessment under medical assistance.

K. If the mental health professional who conducts the diagnostic assessment is not the mental health professional who referred the recipient for the diagnostic assessment or the mental health professional providing psychotherapy, the mental health professional conducting the diagnostic assessment shall request the recipient to authorize release of the information of the diagnostic assessment to the mental health professional who referred the recipient for the diagnostic assessment and the mental health professional who provides the psychotherapy. The authorization must meet requirements in subpart 19 or 20. The mental health professional conducting the diagnostic assessment shall tell the recipient that any mental health professional who provides the recipient's mental health services will need access to the diagnostic assessment to develop an individual treatment plan related to the services recommended in the diagnostic assessment and to receive medical assistance payment for the recipient's mental health services.

L. The mental health professional conducting the diagnostic assessment must complete the diagnostic assessment no later than the second meeting between the recipient and the mental health professional providing the recipient's psychotherapy.

Subp. 5. **Extension of time available to complete a recipient's diagnostic assessment.** The two–hour time limit in subpart 4, item C, for completing the diagnostic assessment does not apply if the mental health professional conducting the diagnostic assessment documents in the recipient's record that the recipient has a condition specified in item A and a circumstance specified in item B, C, or D, is present. In this event, medical assistance will pay for the recipient's diagnostic assessment of up to eight hours in length and the mental health professional conducting the diagnostic assessment must develop the recipient's individual treatment plan. The mental health professional conducting the diagnostic assessment must document in the recipient's record the circumstances requiring the extended time. For purposes of this subpart, "initial diagnostic assessment" refers to the first time that a recipient receives a diagnostic assessment of a set of symptoms indicating a possible mental illness.

A. The recipient has a diagnosis of mental illness and is:

(1) A person with mental retardation as defined in part 9525.0015, subpart 20, or a related condition as defined in Minnesota Statutes, section 252.27, subdivision 1a.

(2) A hearing impaired person as defined in Minnesota Statutes, section 256C.23, subdivision 2.

(3) A person with a speech and language impairment. For purposes of this subitem, "speech and language impairment" means a speech behavior that deviates significantly from the normal or standard speech pattern and attracts attention to the process of speech or interferes with oral communication or adversely affects either the speaker or the listener. An impairment may affect:

(a) the way a sound is formed by persons with cleft palates, cerebral palsy, mental retardation, or related conditions;

(b) the time relationships between sounds, as in stuttering;

(c) the voice, as in a laryngectomy; and

(d) the ease in comprehending the speech of others or in orally projecting one's own ideas, as in cases of aphasia caused by strokes and other cerebral trauma.

(4) A child under 18 years of age who exhibits severe oppositional behavior during the diagnostic assessment, who has not had a previous diagnostic assessment, and whose case record documents the severe oppositional behavior.

(5) A child under 18 years of age whose mental illness results in behavior that unreasonably interferes with the mental health professional's ability to conduct the diagnostic assessment and whose case record documents the behavior.

(6) A person who meets the criteria in subpart 7, item B.

B. An extension of the time for an initial diagnostic assessment is necessary to develop the recipient's individual treatment plan.

C. An extension of the time for an initial diagnostic assessment has been authorized by the case manager according to parts 9525.0015 to 9525.0165.

D. An extension of the time to carry out the activities for a substantial revision of the client's individual treatment plan is necessary because of significant changes in the client's behavior or living arrangement.

Subp. 6. **Prior authorization of additional time to complete a diagnostic assessment.** A mental health professional must obtain prior authorization to exceed the time limits placed on a recipient's diagnostic assessment in subparts 4 and 5. Prior authorization of up to eight hours of diagnostic assessment in a calendar year in addition to the time limit of eight hours available under the circumstances specified in subpart 5 shall be approved if the mental health professional documents that the recipient meets the criteria in subpart 7. The additional hours of assessment must result in an individual treatment plan that has objectives designed to develop adaptive behavior and that specifies the anticipated behavioral change and the expected schedule for achieving the anticipated behavioral change.

Additionally, the request for prior authorization of additional hours to complete the diagnostic assessment must document that the additional hours are necessary and is limited to the additional observation and interviews needed to:

A. establish the baseline measurement of the recipient's behavior;

B. determine the cause of the recipient's behavior such as the recipient's attempts to communicate with others or control his or her environment; and

C. determine the effects of the recipient's physical and social environments on the recipient's behavior.

Subp. 7. **Criteria for prior authorization of additional time to complete a diagnostic assessment.** A request for prior authorization of additional time to complete a recipient's diagnostic assessment shall be approved if the recipient meets the criteria in items A and B or the criteria in item C.

A. The recipient meets the criteria in subpart 5 for extended assessment activity.

B. The recipient has a severe behavior disorder that is manifested as:

(1) Self–injurious behavior that is a clear danger to the recipient. Examples of self–injurious behavior are ingesting inedibles; removing items of clothing; striking, biting, or scratching oneself; moving into dangerous situations that clearly threaten or endanger the recipient's life, sensory abilities, limb mobility, brain functioning, physical appearance, or major physical functions.

(2) Aggressive behavior that is a clear danger to others. Examples of aggressive behaviors are striking, scratching, or biting others; throwing objects at others; attempting inappropriate sexual activity with others; or pushing or placing others into dangerous situations that clearly threaten or endanger their life, sensory abilities, limb mobility, brain functioning, sexual integrity, physical appearance, or other major physical functions.

(3) Destructive behavior that results in extensive property damage.

C. The recipient experienced a significant change in behavior or living arrangement and the recipient meets the criteria in items A and B.

Subp. 8. **Payment rate; diagnostic assessment.** Medical assistance for a diagnostic assessment that meets the requirements in subparts 4 to 7 shall be paid according to the hourly payment rate for individual psychotherapy.

Subp. 9. **Payment limitation; length of psychotherapy session.** Medical assistance payment for a psychotherapy session is limited according to items A to D.

A. The length of an individual psychotherapy session, including hypnotherapy and biofeedback, may be either one–half hour or one hour.

B. The length of a family psychotherapy session shall be one hour or 1–1/2 hours.

C. The length of a group psychotherapy session shall be one hour, 1–1/2 hours, or two hours.

D. If the length of a psychotherapy session is less than an hour or a whole number multiple of an hour, payment will be prorated according to the lesser length of time.

Subp. 10. **Limitations on medical assistance payment for psychotherapy sessions.** There are limitations on medical assistance payment for psychotherapy sessions as specified in the list of health services published according to Minnesota Statutes, section 256B.0625, subdivision 25.

Subp. 11. **Prior authorization of psychotherapy sessions beyond the limitations.** The provider must obtain prior authorization to exceed the limits in subpart 10 unless the psychotherapy session is in response to an emergency as specified in part 9505.5015, subpart 2. In the event of an emergency, the provider must submit a request for prior authorization within five working days after the emergency psychotherapy session.

Subp. 12. **Payment limitation; total payment for group psychotherapy.** To be eligible for medical assistance payment, a group psychotherapy session conducted by one mental health professional shall not have more than eight persons, and a group psychotherapy session conducted by two mental health professionals shall have at least nine but not more than 12 persons. These limits shall apply regardless of the participants' eligibility for medical assistance. Medical assistance payment for each client who participates in a session of group psychotherapy shall be one quarter of the hourly payment rate for an hour of individual psychotherapy. However, in the case of a group pyschotherapy session conducted by two mental health professionals, medical assistance payments shall be according to the number of participants attending the session. When a client participates in a session of group psychotherapy conducted by two mental health professionals, the client's record must document that the cotherapy is medically necessary.

Subp. 13. **Payment limitation; family psychotherapy.** Medical assistance payment for family psychotherapy shall be per psychotherapy session regardless of the medical assistance eligibility status or the number of family members who participate in the family psychotherapy session. Medical assistance payment for family psychotherapy is limited to face–to–face sessions at which the client is present throughout the family psychotherapy session unless the mental health professional believes the client's absence from the family psychotherapy session is necessary to carry out the client's individual treatment plan. If the client is excluded, the mental health professional must document the reason for and the length of the time of the exclusion. Furthermore, the mental health professional must document the reason or reasons why a member of the client's family is excluded.

Subp. 14. **Payment limitation; partial hospitalization.** To be eligible for medical assistance payment, a partial hospitalization program must be reviewed by and have received a letter of approval from the department. Additionally, partial hospitalization must meet the requirements in items A to F.

A. The provider of the partial hospitalization must receive prior authorization before the client's partial hospitalization begins, except as set forth in part 9505.5015, subpart 2.

B. The service is provided to a client who is an outpatient with the diagnosis of mental illness and the service is provided more than 14 days after the client is discharged as an inpatient with a diagnosis of mental illness.

C. A partial hospitalization program for a client who is at least 18 years of age must provide at least six hours of services per day. Medical assistance payment for partial hospitalization is limited to no more than 16 days within a 30 calendar day period. The partial hospitalization must take place on at least four but not more than five days in any week within the 30 calendar day period.

D. A partial hospitalization program for a client who is less than 18 years of age must provide at least five hours of services per day. Medical assistance payment for partial hospitalization is limited to no more than 40 days within a period of ten consecutive weeks. The partial hospitalization must take place on at least four but not more than five days in any week within the ten consecutive week period.

E. The definition of hour in subpart 1, item M, applies to partial hospitalization.

F. Prior authorization may be requested once for up to 16 days of additional partial hospitalization in the case of a client who is at least 18 years of age or for up to 40 days of

additional partial hospitalization in the case of a client who is less than 18 years of age. If the request is approved by the department, the partial hospitalization must comply with the requirements of items A, B, and E, and also with item C in the case of a client who is at least 18 years of age or with the requirements of item D in the case of a client who is less than 18 years of age.

Subp. 15. **Payment limitation; general provisions about day treatment services.** Medical assistance payment for day treatment services to a client shall be limited to 390 hours of day treatment in a calendar year unless prior authorization is obtained for additional hours within the same calendar year. To be eligible for medical assistance payment, a day treatment program must be reviewed by and have received the approval of the department. The treatment must be provided to a group of clients by a multidisciplinary staff under the clinical supervision of a mental health professional. The program must be available at least one day a week for a minimum three–hour time block. The day treatment may be longer than three hours per day but medical assistance payment is limited to three hours per day. To be eligible for medical assistance payment, the three–hour time block must include at least one hour but no more than two hours of individual or group psychotherapy. The remainder of the three–hour time block must consist of any of the following: recreation therapy, socialization therapy, and independent living skills therapy. In addition, the remainder of the three–hour time block can include recreation therapy, socialization therapy, and independent living skills therapy only if they are included in the client's individual treatment plan as necessary and appropriate. Notwithstanding the documentation of each service required under subpart 26, documentation of day treatment may be provided on a daily basis by use of a checklist of available therapies in which the client participated and on a weekly basis by a summary of the information required under subpart 26.

Subp. 16. **Payment limitation; noncovered services provided by day treatment program.** The following services are not covered by medical assistance if they are provided by a day treatment program:

A. A service that is primarily recreation–oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours.

B. A social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness.

C. Consultation with other providers or service agency staff about the care or progress of a client.

D. Prevention or education programs provided to the community.

E. Day treatment for recipients with primary diagnoses of alcohol or other drug abuse.

F. Day treatment provided in the client's home.

G. Psychotherapy for more than two hours daily.

H. Recreation therapy and teaching socialization therapy and independent living skills therapy for more than one hour daily each unless the client's individual treatment plan prescribes more than one hour daily.

I. Participation in meal preparation and eating that is not medically supervised and included in the client's individual treatment plan as necessary and appropriate.

Subp. 17. **Payment limitation; service to determine the need for or to evaluate the effectiveness of prescribed drugs.** Payment for a physician service to a client to determine a client's need for a prescribed drug or to evaluate the effectiveness of a drug prescribed in a client's individual treatment plan is limited according to part 9505.0345, subpart 5. To be covered by medical assistance, the evaluation of the effectiveness of a drug prescribed in a client's individual treatment plan must be carried out face–to–face by a physician or by a mental health professional who is qualified in psychiatric nursing as specified in Minnesota Statutes, section 245.462, subdivision 18, clause (1), or a registered nurse who is qualified as a mental health practitioner as specified in Minnesota Statutes, section 245.462, subdivision 17. A nurse who evaluates a client's prescribed drugs must be employed by or under contract to a provider and must be under the supervision of a physician who is on site at least 50 per-

cent of the time the service is being provided. For purposes of this subpart, "evaluation of the effectiveness of a drug prescribed in a client's individual treatment plan" or "evaluation of a client's prescribed drugs" means adjusting a client's medication to mitigate the client's symptoms, alleviate the client's distress, and determine the impact of the client's medication on the client's functioning at work and in daily living.

Subp. 18. **Payment limitation; explanation of findings.** Explanation of findings is a covered service under parts 9505.0170 to 9505.0475. Medical assistance payment for explanations of findings is limited to four hours per recipient per calendar year. Unless the recipient's diagnostic assessment meets the requirements of subparts 5 to 7, medical assistance payment will not pay for more than a one–hour explanation of findings after the mental health professional completes the recipient's diagnostic assessment. The mental health professional providing the explanation of findings may use the time available under this subpart for an explanation of findings in units of one–half hour or one hour but the total must not exceed the amount specified in this subpart. To be eligible for medical assistance payment, the mental health professional providing the explanation of findings must have obtained the authorization of the recipient or the recipient's representative to release the information as required in subpart 19 or 20. If the recipient's diagnostic assessment qualifies for an extension of or additional time as provided in subparts 5 to 7, the mental health professional providing the explanation of findings may allocate the calendar year total of four hours in any manner necessary to explain the findings. Medical assistance only pays for the actual time spent or four hours, whichever amount of time is less.

Subp. 19. **Authorization to access or release information about a recipient.** To obtain medical assistance payment, in the case of a client who is an adult, a mental health professional providing a mental health service must ask a recipient or the recipient's legal representative to sign forms needed to authorize access or release of information about a recipient's health status. The form must contain the information in items A to H and room for the person's signature. If the recipient or the recipient's legal representative refuses to sign the authorization, the mental health professional must not access or release the information and must document the refusal to sign and the reason for the refusal in the recipient's record. The period of authorization must not exceed one year. The authorization form must state:

A. the person's name;

B. the date;

C. the specific nature of the information authorized to be accessed or released;

D. who is authorized to give information;

E. to whom the information is to be given;

F. the information's use;

G. the date of expiration of the authorization; and

H. that the recipient may revoke consent at any time.

For purposes of this subpart and subpart 20, "legal representative" means a guardian or conservator authorized by the court to make decisions about services for a person, or other individual authorized to consent to services for the person.

Subp. 20. **Authorization to provide service or to access or release information about a recipient who is a child.** To obtain medical assistance payment, in the case of a client who is a child, a mental health professional who wants to provide a mental health service to a child or who is required to access or release information related to the child's mental health status and services must obtain the authorization of the child's parent or legal representative unless a condition specified in item A, B, or C, applies.

The authorization of service must state the child's name, the service or services authorized, the person or persons authorized to provide the service, the amount, frequency, scope, and duration of each service, the goals of the service, the date of the authorization, and the relationship between the person giving the authorization and the child. The authorization to access or release information must comply with subpart 19, items A to H. An authorization of services under this subpart must not exceed one year. Authorization by the child's parent or legal representative is not required if:

A. The parent or legal representative is hindering or impeding the child's access to mental health services.

B. The child:

(1) has been married or has borne a child as specified in Minnesota Statutes, section 144.342;

(2) is living separate and apart from the child's parents or legal guardian and is managing the child's financial affairs as specified in Minnesota Statutes, section 144.341;

(3) is at least 16 but under 18 years old and has consented to treatment as specified in Minnesota Statutes, section 253B.03, subdivision 6; or

(4) is at least 16 but under 18 years old and for whom a county board has authorized independent living pursuant to a court order as specified in Minnesota Statutes, section 260.191, subdivision 1, paragraph (a), clause (4).

C. A petition has been filed under Minnesota Statutes, chapter 260, or a court order has been issued under Minnesota Statutes, section 260.133 or 260.135, and a guardian ad litem has been appointed.

If item A or B applies, the mental health professional shall request the child to complete the required forms.

If item C applies, the mental health professional shall request the guardian ad litem to complete the required forms.

Subp. 21. **Payment limitation; psychological testing.** Medical assistance payment for psychological testing of a recipient in a calendar year shall not exceed eight times the medical assistance payment rate for an hour of individual psychotherapy. Psychological testing shall be reimbursed according to the psychological test used. The psychological testing must be conducted by a psychologist with competence in the area of psychological testing as stated to the board of psychology. The psychological testing must be validated in a face–to–face interview between the recipient and a licensed psychologist or licensed consulting psychologist with competence in the area of psychological testing. The report resulting from the psychological testing must be signed by the psychologist conducting the face–to–face interview, must be placed in the recipient's record, and must be released to each person authorized by the recipient. The required components of psychological testing, which include face–to–face interview, interpretation, scoring of the psychological tests, and the required report of testing, are not eligible for a separate charge to medical assistance. Payment for these required components is included in the amount paid for the psychological testing. The administration, scoring, and interpretation of the psychological tests may be carried out, under the clinical supervision of a licensed psychologist or licensed consulting psychologist, by a psychometrist or psychological assistant or as part of a computer–assisted psychological testing program.

Subp. 22. [Repealed, 17 SR 1454]

Subp. 23. **Medical assistance payment for mental health services; required personnel.** A mental health service provided by a mental health professional or a mental health practitioner as specified in subpart 31 is a covered service. A mental health service other than day treatment; partial hospitalization; service provided by a mental health practitioner according to subpart 31; individual, family, or group skills training as a component of home–based mental health services; or a mental health case management service under part 9505.0322 that is provided by a mental health practitioner is not eligible for medical assistance payment. To be eligible for medical assistance payment, services provided by a mental health practitioner according to this subpart must be under the clinical supervision of a mental health professional who is a provider.

Subp. 24. **Payment limitation; person completing requirements for licensure or board certification as mental health professional.** Medical assistance payment is available for mental health services provided by a person who has completed all requirements for licensure or board certification as a mental health professional except the requirements for supervised experience in the delivery of mental health services in the treatment of mental illness under this subpart. Mental health services may also be provided by a person who is a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional. The person providing the ser-

vice must be under the clinical supervision of a fully qualified mental health professional who is a provider. The person must be employed by or placed in an outpatient hospital, a physician–directed clinic, a community mental health center, or a facility approved for insurance reimbursement according to parts 9520.0750 to 9520.0870. Medical assistance for services performed according to this subpart shall be paid at one–half the medical assistance payment rate for the same service provided by a fully qualified person.

Subp. 25. **Individual treatment plan.** Except as provided in subpart 3, medical assistance payment is available only for services in accordance with the client's individual treatment plan. The individual treatment plan must meet the standards of this subpart. A client's individual treatment plan must be based on the information and outcome of the client's diagnostic assessment conducted as specified in subpart 4. Except as provided in subparts 5 and 6, the individual treatment plan must be developed by the mental health professional who provides the client's psychotherapy, or the mental health practitioner who is under the clinical supervision of a mental health professional who is a provider and must be developed no later than the end of the first psychotherapy session after the completion of the client's diagnostic assessment. The mental health professional or the mental health practitioner must involve the client in the development, review, and revision of a client's individual treatment plan. The plan must be reviewed at least once every 90 days, and if necessary revised. However, revisions of the initial individual treatment plan do not require a new diagnostic assessment unless the client's mental health status has changed markedly as provided in subpart 4, item A. The mental health professional shall request the client, or in the case of a child whose circumstances do not fall within subpart 21, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child, to sign the client's individual treatment plan and revision of the plan unless the request is not appropriate to the client's mental health status. If the client refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner shall note on the plan the client's refusal to sign the plan and the client's reason or reasons for the refusal. If the client's mental health status contraindicates the request, the mental health professional or mental health practitioner shall note on the plan the reason the client was not requested to sign the plan.

Subp. 26. **Documentation of the provision of mental health service.** To obtain medical assistance payment, a mental health professional or a mental health practitioner providing a mental health service must document in the client's record (1) each occurrence of the client's service including the date, type, length, and scope of the mental health service; (2) the name of the person who gave the service; (3) contact made with other persons interested in the recipient such as representatives of the courts, corrections systems, or schools including the name and date of the contact; (4) any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or, if applicable, the reason the client's family members, primary caregiver, or legal representative was not contacted; and (5) as appropriate, required clinical supervision. The documentation must be completed promptly after the provision of the service.

Subp. 27. **Excluded services.** The mental health services in items A to S are not eligible for medical assistance payment:

A. a mental health service that is not medically necessary;

B. a mental health service exceeding the limitations in subparts 6, 11, 14, and 15, that has not received prior authorization;

C. a mental health service other than a diagnostic assessment, psychological testing, explanation of findings, or one hour of psychotherapy before completion of the diagnostic assessment to a recipient who has not been determined to have a mental illness;

D. a diagnostic assessment that requires the clinical supervision of a provider, and the mental health service or services provided in response to the diagnosis made in the diagnostic assessment, if the clinical supervision was not provided;

E. a mental health service other than a diagnostic assessment, psychological testing, explanation of findings, or one hour of psychotherapy before completion of the diagnostic assessment if the service is not recommended by a mental health professional and is not part of an individual treatment plan;

F. a neurological examination carried out by a person other than a psychiatrist or psychologist with a competency in the area of neuropsychological evaluation listed with the board of psychology as in part 7200.4600, subpart 1;

G. a mental health service provided to a resident of a long–term care facility other than an intermediate care facility for the mentally retarded without the written order of the recipient's attending physician;

H. a service provided to a resident of an intermediate care facility for the mentally retarded if the service is not specified on the resident's individual service plan as set forth in part 9525.0075;

I. an evaluation of a prescribed drug by a person other than a physician or a person supervised by a physician and qualified in psychiatric nursing or as a registered nurse;

J. a service ordered by a court that is solely for legal purposes and not related to the recipient's diagnosis or treatment for mental illness;

K. services dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health;

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

M. staff training that is not related to a client's individual treatment plan or plan of care;

N. child and adult protection services provided directly or indirectly by a governmental entity;

O. mental health services other than psychological testing of a recipient who is an inpatient for the purposes of psychiatric treatment;

P. psychological testing, diagnostic assessment, explanation of findings, and psychotherapy if the services are provided by a school or a local education agency unless the school or local education agency is a provider and the services are medically necessary and prescribed in a child's individual education plan;

Q. psychological testing, diagnostic assessment, explanation of findings, and psychotherapy if the services are provided by an entity whose purpose is not health service related such as the Division of Vocational Rehabilitation of the Department of Jobs and Training;

R. fundraising activities; and

S. community planning.

Subp. 28. **Multiple family group psychotherapy.** A multiple family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least three but not more than five families. Medical assistance payment for a multiple family group shall be limited to one session of up to two hours per week for no more than ten weeks.

Subp. 29. **Required participation of psychiatrist in treatment of person with serious and persistent mental illness or child with severe emotional disturbance.** A psychiatrist or, in the case of a child with severe emotional disturbance, a psychiatrist or a provider as specified in item B must participate in the diagnostic assessment, formulation of an individual treatment plan, and monitoring of the clinical progress of a client as specified in item A or B. The extent of the participation of the psychiatrist or, in the case of a child with severe emotional disturbance, a psychiatrist or a provider as specified in item B shall be according to the individual clinical needs of the client as mutually determined by the mental health professional who is conducting the assessment and by the psychiatrist or, in the case of a child with severe emotional disturbance, a psychiatrist or a provider as specified in item B who participates. At a minimum, the participation must consist of timely reviews of the activities specified in this subpart and verbal interaction between the psychiatrist or, in the case of a child with severe emotional disturbance, a psychiatrist or a provider as specified in item B and the mental health professional. The following cases require participation:

A. When a client who has a mental illness that meets the definition of serious and persistent mental illness under Minnesota Statutes, section 245.462, subdivision 20, paragraph (c), is currently under the care of a psychiatrist, and is receiving antipsychotic or antidepressant medication.

B. When the client is a child with a severe emotional disturbance who meets the definition under Minnesota Statutes, section 245.4871, subdivision 6, is currently under the care of a psychiatrist, and is receiving antipsychotic or antidepressant medication for treatment of a depressive illness. In the case of a child with severe emotional disturbance whose response to psychoactive drugs other than antipsychotic and antidepressant medication is being followed by a physician who is a behavioral pediatrician or a neurologist, the required participation must be provided by a psychiatrist or provider who is competent to prescribe and monitor the effects of psychoactive medication for a pediatric population with severe emotional disturbance. When a child with a severe emotional disturbance is receiving an antidepressant medication for treating a condition other than a depressive illness, the participation of a psychiatrist is not required but the child's response to the antidepressant medication must be monitored by a behavioral pediatrician or neurologist.

Subp. 30. **Group psychotherapy for crisis intervention.** Group psychotherapy provided to a client on a daily basis for crisis intervention is eligible for medical assistance payment as specified in items A to D.

A. The group psychotherapy must be necessary to meet the client's crisis.

B. At least three but not more than nine persons, regardless of their medical assistance eligibility, must participate in the crisis group.

C. For each crisis episode, the client may receive up to three hours per week within a period of two calendar weeks unless prior authorization is obtained for additional hours per week.

D. The number of hours of group psychotherapy provided for crisis intervention shall be included within the limit specified in subpart 10 unless prior authorization is obtained.

For the purpose of this subpart, "crisis" means any acute social, interpersonal, environmental, or intrapersonal stress that threatens the client's current level of adjustment or causes significant subjective distress.

Subp. 31. **Medical assistance payment for mental health services by mental health practitioner.** Notwithstanding other provisions of this part, a mental health service provided by a mental health practitioner is a covered service if the mental health practitioner has the qualifications in items A to C and the service is provided under the clinical supervision of a mental health professional. Medical assistance for services performed according to this subpart shall be paid at one–half the medical assistance payment rate for the same service provided by a mental health professional.

A. The mental health practitioner holds at least a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university.

B. The mental health practitioner is employed by a private nonprofit entity specializing in mental health services to low–income children under age 15.

C. The mental health practitioner has provided outpatient mental health services with a primary emphasis on family–oriented mental health services, to children under age 15, under clinical supervision for at least ten years after receiving a bachelor's degree.

For purposes of this subpart, "low–income children under age 15" refers to children under age 15 in a family having a gross family income equal to or less than 185 percent of the federal poverty guidelines for the same family size.

Subp. 32. **Coordination of services.** If a recipient receives mental health services from more than one mental health professional or mental health practitioner, the persons providing the services must coordinate the mental health services they provide to the recipient.

Statutory Authority: *MS s 245.484; 256B.04; 256B.0625; L 1990 c 568 art 3 s 97*

History: *14 SR 8; 16 SR 59; 17 SR 1454; 18 SR 390*

9505.0324 HOME–BASED MENTAL HEALTH SERVICES.

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

A. "Child" means a person under age 21 who is eligible for early periodic screening, diagnostic, and treatment services under parts 9505.1693 to 9505.1748 and who has been determined to be in need of home–based mental health services.

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

C. "Emotional disturbance" refers to the term defined in Minnesota Statutes, section 245.4871, subdivision 15, and, in addition, to a person at least age 18 but under age 21 who has a mental illness as defined in Minnesota Statutes, section 245.462, subdivision 20, paragraph (a).

D. "Home–based mental health services" means a culturally appropriate, structured program of intensive mental health services provided to a child with severe emotional disturbance who is at risk of out–of–home placement because of an event or condition which exacerbates the child's severe emotional disturbance or a child who is returning from out–of–home placement because of the severe emotional disturbance. The purposes of the services are aimed at resolving an acute episode of emotional disturbance affecting the child with the severe emotional disturbance or the child's family, in order to reduce the risk of the child's out–of–home placement, or to reunify and reintegrate the child with the child's family after an out–of–home placement. The services are provided primarily in the child's residence but may also be provided in the child's school, the home of a relative of the child, a recreational or leisure setting, or the site where the child receives day care. For purposes of this part, home–based mental health services is used as synonymous with "professional home–based family treatment" as defined in Minnesota Statutes, section 245.4871, subdivision 31.

E. "Individual treatment plan" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 21.

F. For purposes of this part, "residence" as defined in part 9505.0175, subpart 43, does not include a group home as defined by part 9560.0520, subpart 4, a residential treatment facility licensed under parts 9545.0900 to 9545.1090, an acute care hospital licensed under Minnesota Statutes, chapter 144, a regional treatment center or other institutional group setting, or a foster family home in which the foster parent is not the primary caregiver and does not reside with the child.

Subp. 2. **Eligible providers of home–based mental health services.** The entities in items A to D are eligible to provide home–based mental health services if they meet the requirements of subparts 4 and 5:

A. outpatient hospitals licensed under Minnesota Statutes, section 144.50;

B. community mental health centers providing community mental health center services as specified in part 9505.0260;

C. an entity approved by the commissioner as specified in parts 9520.0750 to 9520.0870; and

D. a county board. For purposes of this item, "county board" means the county board of commissioners or a board established under Minnesota Statutes, sections 402.01 to 402.10 or 471.59. A county board may only contract with an entity specified in items A to C. An entity specified in items A to C under contract to the county board to provide home–based mental health services must provide the required services and may not contract for the home–based mental health services with another party. The persons who provide the services must be employees of the entity under contract with the county board for the home–based mental health services. For purposes of this item, "employee" means a person employed by a provider who pays compensation to the employee and who withholds or is required to withhold federal and state taxes from the employee's compensation. An employee is not a self–employed vendor or independent contractor who has a contract with a provider.

Subp. 3. **Eligibility to receive home–based mental health services.** Home–based mental health services are available to a child who has been determined to be a child with severe emotional disturbance who needs home–based mental health services. The determination of a child's eligibility to receive home–based mental health services under this part shall be based on a diagnostic assessment as defined in Minnesota Statutes, section 245.4871, subdivision 11, for a child under age 18 or a diagnostic assessment as defined in Minnesota Statutes, section 245.462, subdivision 9, for a child at least age 18 but under age

21. The diagnostic assessment may be a service under early periodic screening, diagnosis, and treatment established in United States Code, title 42, section 1396d(r).

Subp. 4. **Eligibility for medical assistance payment.** To be eligible for medical assistance payment, the provider of home–based mental health services must meet the requirements in items A to E. The home–based mental health services provider must assist the case manager, if any, in coordinating other services to the child.

A. The services must be provided by mental health professionals and mental health practitioners who are skilled in the delivery of mental health services to children and their families.

B. The services must be designed to meet the specific mental health needs of the child and the child's family according to the child's individual treatment plan developed by the provider with specific treatment goals and objectives for the child and the child's family.

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

D. The caseload of a home–based mental health services provider must be of a size that can reasonably be expected to enable the provider to meet the needs of the children and their families in the provider's caseload and permit the delivery of the services specified in the children's individual treatment plans.

E. The services must be coordinated with the child's case manager for mental health services if the child is receiving case management services.

Subp. 5. **Components of home–based mental health services.** An eligible provider of home–based mental health services specified in subpart 2 must be capable of providing all of the components specified in this subpart. However, a provider is responsible to provide a component only if the component is specified in a child's individual treatment plan. The components are:

A. diagnostic assessment as specified in part 9505.0323;

B. individual psychotherapy, family psychotherapy, and multiple–family group psychotherapy as defined in part 9505.0323; and

C. individual, family, or group skills training designed to improve the basic functioning of the child with severe emotional disturbance and the child's family in the activities of daily living and community living, and to improve the social functioning of the child and the child's family in areas important to the child's maintaining or reestablishing residency in the community. For purposes of this item, "community" means the child's residence, work, school, or peer group. The individual, family, and group skills training must:

(1) consist of activities designed to promote skill development of the child and the child's family in the use of age–appropriate daily living skills, interpersonal and family relationships, and leisure and recreational services;

(2) consist of activities which will assist the family to improve the family's understanding of normal child development and to use parenting skills that will help the child with severe emotional disturbance achieve the goals outlined in the child's individual treatment plan; and

(3) promote family preservation and unification, promote the family's integration with the community, and reduce the use of unnecessary out–of–home placement or institutionalization of children with severe emotional disturbance.

Subp. 6. **Excluded services.** The services specified in items A to K are not eligible for medical assistance payment:

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

B. more than 192 hours of individual, family, or group skills training within a six–month period;

C. more than a combined total of 48 hours within a six–month period of individual psychotherapy, family psychotherapy, and multiple–family group psychotherapy, except in

the case of an emergency and prior authorization or after–the–fact authorization of the psychotherapy is obtained under part 9505.5015;

D. home–based mental health services that exceed 240 hours in any combination of the psychotherapies and individual, family, or group skills training within a six–month period. Additional home–based mental health services beyond 240 hours are eligible for medical assistance payment with prior authorization;

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

F. individual, family, or group skills training provided by a person who is not qualified, at least, as a mental health practitioner as specified in Minnesota Statutes, section 245.4871, subdivision 26, and who does not maintain a consulting relationship with a mental health professional who accepts full professional responsibility. However, medical assistance shall reimburse a mental health practitioner who maintains a consulting relationship with a mental health professional who accepts full professional responsibility and is present on–site at least for one observation during the first 12 hours in which the mental health practitioner provides the individual, family, or group skills training to the child with severe emotional disturbance or the child's family. Thereafter, the mental health professional is required according to this subpart, to be present on–site for observation as clinically appropriate when the mental health practitioner is providing individual family or group skills training to the child and the child's family. The observation must be a minimum of one clinical unit. The on–site presence of the mental health professional must be documented in the child's record and signed by the mental health professional who accepts full professional responsibility;

G. home–based mental health services provided by an entity specified in subpart 2 if the entity is not capable of providing all the components required in subpart 5;

H. home–based mental health services simultaneously provided by more than one mental health professional or mental health practitioner unless prior authorization is obtained;

I. home–based mental health services to a child or the child's family that duplicate health services funded under part 9505.0323, grants authorized according to Minnesota Statutes, section 245.4886, the Minnesota family preservation act, Minnesota Statutes, section 256F.03, subdivision 5, paragraph (e), or the Minnesota Indian family preservation act, Minnesota Statutes, sections 257.35 to 257.3579, except as provided in subitem (1) or (2):

(1) up to 60 hours of day treatment services under part 9505.0323 within a six–month period provided concurrently with home–based mental health services to a child with severe emotional disturbance are eligible for medical assistance payment without prior authorization if the child is being phased out of day treatment services and phased into home–based mental health services or if the child is being phased out of home–based mental health services and phased into day treatment services and the home–based mental health services and day treatment services are identified with the goals of the child's individual treatment plan. Prior authorization may be requested for additional hours of day treatment beyond the 60–hour limit; or

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

J. home–based mental health services provided to a child with severe emotional disturbance who is not living in the child's residence. However, up to 35 hours of home–

based mental health services provided within a six–month period to a child with severe emotional disturbance who is residing in a hospital, a group home as defined in part 9560.0520, subpart 4, a residential treatment facility licensed under parts 9545.0900 to 9545.1090, a regional treatment center, or other institutional group setting or who is participating in a program of partial hospitalization are eligible for medical assistance payment if the services are provided under an individual treatment plan for the child developed by the provider working with the child's discharge planning team and if the services are needed to assure the child's smooth transition to living in the child's residence; and

K. home–based mental health services provided in violation of any provision of subparts 1 to 5.

Subp. 7. **Required training.** A provider that employs a mental health practitioner to provide home–based mental health services under this part must require the mental health practitioner to complete 15 hours of continuing education per calendar year. The continuing education shall be related to serving the needs of children with severe emotional disturbance in the child's residence and the child's family. The provider shall document completion of the required continuing education on an annual basis.

Subp. 8. **Travel to the child's treatment site.** Travel by a mental health professional to and from the site where the mental health professional provides home–based mental health services to a child is eligible for medical assistance payment. Medical assistance payment to a mental health professional who travels to and from the site where the professional provides home–based mental health services to a recipient shall not exceed payment for more than 128 hours of travel per client in a six–month period. The commissioner's implementation of this subpart shall be subject to approval by the Health Care Financing Administration of the United States Department of Health and Human Services. Payment for travel under this subpart shall be at the hourly rate paid to a case manager for case management services under part 9505.0491, subparts 7 and 8.

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

History: *17 SR 1455*

9505.0325 NUTRITIONAL PRODUCTS.

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

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

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

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

A. phenylketonuria;

B. hyperlysinemia;

C. maple syrup urine disease; or

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

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

Subp. 6. **Payment limitations; long–term care facilities and hospitals.** An enteral nutritional product for a recipient in a long–term care facility or hospital is not eligible for payment on a separate claim for payment. Payment must be made according to parts 9500.1090 to 9500.1155, 9549.0010 to 9549.0080, 9549.0050 to 9549.0059 as published in

the State Register, December 1, 1986, volume 11, number 22, pages 991 to 1004, and 9553.0010 to 9553.0080.

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0330 OUTPATIENT HOSPITAL SERVICES.

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

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

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

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

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

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

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

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

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

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

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

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

A. diapers;

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0335 PERSONAL CARE SERVICES.

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

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

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

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

(3) needs; and

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

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

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

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

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

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

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

H. "Qualified recipient" means a recipient who needs personal care services to live independently in the community, is in a stable medical condition, and does not have acute care needs that require inpatient hospitalization or cannot be met in the recipient's residence by a nursing service as defined by Minnesota Statutes, section 148.171, clause (3).

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

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

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

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

B. The recipient is a qualified recipient.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. comply with part 9505.0210;

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

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

G. provide a quality assurance mechanism;

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

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

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

K. demonstrate a system of personnel management; and

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

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

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

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

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

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

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

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

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

H. comply with applicable rules and statutes; and

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

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

A. refuses to provide full disclosure of criminal history records as specified in subpart 12;

B. has been convicted of a crime that directly relates to the occupation of providing personal care services to a qualified recipient;

C. has jeopardized the health or welfare of a vulnerable adult through physical abuse, sexual abuse, or neglect as defined in Minnesota Statutes, section 626.557; or

D. is misusing or is dependent on mood altering chemicals including alcohol to the extent that the personal care provider knows or has reason to believe that the use of chemicals has a negative effect on the person's ability to provide personal care services or the use of chemicals is apparent during the hours the person is providing personal care services.

Subp. 8. **Payment limitation; general.** Except as in subpart 9, personal care services eligible for medical assistance payment are limited to items A to N:

A. bowel and bladder care;

B. skin care, including prophylactic routine and palliative measures documented in the plan of care that are done to maintain the health of the skin. Examples are exposure to air, use of nondurable medical equipment, application of lotions, powders, ointments, and treatments such as heat lamp and foot soaks;

C. range of motion exercises;

D. respiratory assistance;

E. transfers;

F. bathing, grooming, and hairwashing necessary for personal hygiene;

G. turning and positioning;

H. assistance with furnishing medication that is ordinarily self administered;

I. application and maintenance of prosthetics and orthotics;

J. cleaning equipment;

K. dressing or undressing;

L. assistance with food, nutrition, and diet activities;

M. accompanying a recipient to obtain medical diagnosis or treatment and to attend other activities such as church and school if the personal care assistant is needed to provide personal care services while the recipient is absent from his or her residence; and

N. performing other services essential to the effective performance of the duties in items A to M.

Subp. 9. **Shared personal care services.** The shared personal care services in items A to D are eligible for medical assistance payment:

A. personal care services in subpart 8;

B. services provided for the recipient's personal health and safety;

C. monitoring and control of a recipient's personal funds as required in the plan of care; and

D. helping the recipient to complete daily living skills such as personal and oral hygiene and medication schedules.

Subp. 10. **Excluded services.** The services in items A to G are not covered under medical assistance as personal care services:

A. a health service provided by and billed by a provider who is not a personal care provider;

B. a homemaking and social service except as provided in subpart 8, item N, or subpart 9;

C. personal care service that is not in the plan of personal care services;

D. personal care service that is not supervised by a registered nurse;

E. personal care service that is provided by a person who is the recipient's legal guardian or related to the recipient as spouse, parent, or child whether by blood, marriage, or adoption;

F. sterile procedures except for routine, intermittent catheterization; and

G. giving of injections of fluids into veins, muscles, or skin.

Subp. 11. **Maximum payment.** The maximum medical assistance payment for personal care services to a recipient shall be subject to the payment limitations established for home health services in part 9505.0295, subpart 3.

Subp. 12. **Preemployment check of criminal history.** Before employing a person as a personal care assistant of a qualified recipient, the personal care provider shall require from the applicant full disclosure of conviction and criminal history records pertaining to any crime related to the provision of health services or to the occupation of a personal care assistant.

Subp. 13. **Overutilization of personal care services.** A personal care provider who is found to be providing personal care services that are not medically necessary shall be prohibited from participating in the medical assistance program. The determination of whether excess services are provided shall be made by a screening team or according to parts 9505.2160 to 9505.2245. The termination of the personal care provider shall be consistent with the contract between the provider and the department.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624; L 1990 c 375 s 3*

9505.0340 PHARMACY SERVICES.

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

A. "Actual acquisition cost" means the cost to the provider including quantity and other special discounts except time and cash discounts.

B. "Compounded prescription" means a prescription prepared under part 6800.3100.

C. "Dispensing fee" means the amount allowed under the medical assistance program as payment for the pharmacy service in dispensing the prescribed drug.

D. "Maintenance drug" means a prescribed drug that is used by a particular recipient for a period greater than two consecutive months.

E. "Pharmacist" means a person licensed under Minnesota Statutes, chapter 151, to provide services within the scope of pharmacy practice.

F. "Pharmacy" means an entity registered by the Minnesota Board of Pharmacy under Minnesota Statutes, chapter 151.

G. "Pharmacy service" means the dispensing of drugs under Minnesota Statutes, chapter 151 or by a physician under subpart 2, item B.

H. "Prescribed drug" means a drug as defined in Minnesota Statutes, section 151.01, subdivision 5, and ordered by a practitioner.

I. "Practitioner" means a physician, osteopath, dentist, or podiatrist licensed under Minnesota Statutes or the laws of another state or Canadian province to prescribe drugs within the scope of his or her profession.

J. "Usual and customary charge" refers to the meaning in part 9505.0175, subpart 49, whether the drug is purchased by prescription or over the counter, in bulk, or unit dose packaging. However, if a provider's pharmacy is not accessible to, or frequented by, the general public, or if the over the counter drug is not on display for sale to the general public, then the usual and customary charge for the over the counter drug shall be the actual acquisition cost of the product plus a 50 percent markup based on the actual acquisition cost. In this event, this calculated amount must be used in billing the department for an over the counter drug.

Amounts paid in full or in part by third–party payers shall be included in the calculation of the usual and customary charge only if a third–party payer constitutes 51 percent or more of the pharmacy's business based on the number of prescriptions filled by the pharmacy on a quarterly basis.

Subp. 2. **Eligible providers.** The following providers are eligible for payment under the medical assistance program for dispensing prescribed drugs:

A. a pharmacy that is licensed by the Minnesota Board of Pharmacy;

B. an out–of–state vendor under part 9505.0195, subpart 9; and

C. a physician located in a local trade area where there is no enrolled pharmacy. The physician to be eligible for payment shall personally dispense the prescribed drug according to Minnesota Statutes, section 151.37, and shall adhere to the labeling requirements of the Minnesota Board of Pharmacy.

Subp. 3. **Payment limitations.** Payments for pharmacy services under the medical assistance program are limited as follows.

A. The prescribed drug must be a drug or compounded prescription that is approved by the commissioner for inclusion in the department's drug formulary. The drug formulary committee established under Minnesota Statutes, sections 256B.02, subdivision 8 and 256B.0625, shall recommend to the commissioner the inclusion of a drug or compounded prescription in the drug formulary. The commissioner may add or delete a drug or compounded prescription from the drug formulary. A provider, recipient, or seller of prescription drugs or compounded prescriptions may apply to the department on the form specified in the drug formulary to add or delete a drug from the drug formulary.

B. A prescribed drug must be dispensed in the quantity specified on the prescription unless the pharmacy is using unit dose dispensing or the specified quantity is not available in the pharmacy when the prescription is dispensed. Only one dispensing fee is allowed for dispensing the quantity specified on the prescription.

C. The dispensed quantity of a prescribed drug must not exceed a three month supply unless prior authorization is obtained by the pharmacist or dispensing physician.

D. An initial or refill prescription for a maintenance drug shall be dispensed in not less than a 30 day supply unless the pharmacy is using unit dose dispensing. No additional dispensing fee shall be paid until that quantity is used by the recipient.

E. Except as in item F, the dispensing fee billed by or paid to a particular pharmacy or dispensing physician for a maintenance drug for a recipient is limited to one fee per 30 day supply.

F. More than one dispensing fee per calendar month for a maintenance drug for a recipient is allowed if the record kept by the pharmacist or dispensing physician documents that there is a significant chance of overdosage by the recipient if a larger quantity of drug is dispensed, and if the pharmacist or dispensing physician writes a statement of this reason on the prescription.

G. A refill of a prescription must be authorized by the practitioner. Refilled prescriptions must be documented in the prescription file, initialed by the pharmacist who refills the prescription, and approved by the practitioner as consistent with accepted pharmacy practice under Minnesota Statutes, chapters 151 and 152.

H. A generically equivalent drug as defined in Minnesota Statutes, section 151.21, subdivision 2, must be dispensed in place of the prescribed drug if:

(1) the generically equivalent drug is approved by the United States Food and Drug Administration and is also determined as therapeutically equivalent by the United States Food and Drug Administration; and

(2) in the professional judgment of the pharmacist, the substituted drug is therapeutically equivalent to the prescribed drug; and

(3) the charge for the substituted generically equivalent drug does not exceed the charge for the drug originally prescribed.

However, a substitution must not be made if the practitioner has written in his or her own handwriting "Dispense as Written" or "DAW" on the prescription, as provided in the Minnesota Drug Selection Act, Minnesota Statutes, section 151.21. The pharmacy must notify the recipient and the department when a generically equivalent drug is dispensed. The notice to the recipient may be given orally or by appropriate labeling on the prescription's container. The notice to the department must be by appropriate billing codes.

I. Unless otherwise established by the legislature, the amount of the dispensing fee shall be set by the commissioner. The fee shall be the lower of the average dispensing fee set by third–party payers in the state or the average fee determined by a cost of operation survey of pharmacy providers reduced by the yearly consumer price index (urban) for the Minneapolis–Saint Paul area to the base year set by the legislature for other provider fees.

J. The cost of delivering a drug is not a covered service.

Subp. 4. **Payment limitations; unit dose dispensing.** Drugs dispensed under unit dose dispensing in accordance with part 6800.3750 shall be subject to the medical assistance payment limitations in items A to C.

A. Dispensing fees for drugs dispensed in unit dose packaging as specified in part 6800.3750 shall not be billed or paid more often than once per calendar month or when a minimum of 30 dosage units have been dispensed, whichever results in the lesser number of dispensing fees, regardless of the type of unit dose system used by the pharmacy or the number of times during the month that the pharmacist dispenses the drug. If the recipient's drug supply is dispensed in small increments during the calendar month, the pharmacy must keep a written record of each dispensing act that shows the date, National Drug Code, and the quantity of the drug dispensed.

B. Only one dispensing fee per calendar month shall be billed or paid for each maintenance drug regardless of the type of unit dose system used by the pharmacy or the number of times during the month that the pharmacist dispenses the drug. If the recipient's drug supply is dispensed in small increments during the month, the pharmacy must keep a written record of each dispensing act that shows the date, National Drug Code, and the quantity of drug dispensed.

C. The date of dispensing must be reported as the date of service on the claim to the department except when the recipient's drug supply is dispensed in small increments during the month. For this exception, the last dispensing date of the calendar month must be reported on the claim to the department as the date of service. In the case of an exception, the quantity of drug dispensed must be reported as the cumulative total dispensed during the month or a minimum amount as required in item A, whichever results in the lesser number of dispensing fees.

Subp. 5. **Return of drugs.** Drugs dispensed in unit dose packaging under part 6800.3750, subpart 2, shall be returned to a pharmacy as specified in items A to C when the recipient no longer uses the drug.

A. A provider of pharmacy services using a unit dose system must comply with part 6800.2700.

B. A long-term care facility must return unused drugs dispensed in unit dose packaging to the provider that dispensed the drugs.

C. The provider that receives the returned drugs must repay medical assistance the amount billed to the department as the cost of the drug.

Subp. 6. **Billing procedure.** Providers of pharmacy services shall bill the department their usual and customary charge for the dispensed drug. All pharmacy claims submitted to the department must identify the National Drug Code printed on the container from which the prescription is actually filled. If a National Drug Code is not printed on the manufacturer's container from which the prescription is filled, the claim must name the code required by the department under the drug formulary, or identify either the generic or brand name of the drug. Except as provided in subpart 4, item C, the date reported as the date dispensed must be the date on which the quantity reported on the billing claim was dispensed.

Subp. 7. **Maximum payment for prescribed drugs.** The maximum payment for a prescribed drug or compounded prescription under the medical assistance program must be the lowest of the following rates:

A. The maximum allowable cost for a drug established by the department or the Health Care Financing Administration of the United States Department of Health and Human Services plus a dispensing fee.

B. The actual acquisition cost for a drug plus a dispensing fee.

C. The pharmacy's usual and customary charge.

Statutory Authority: *MS s 256B.04 subds 4,12*

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

9505.0345 PHYSICIAN SERVICES.

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

A. "Physician directed clinic" means an entity with at least two physicians on staff which is enrolled in the medical assistance program to provide physician services.

B. "Physician's employee" means a nurse practitioner or physician assistant, mental health practitioner, or mental health professional.

C. "Physician service" means a medically necessary health service provided by or under the supervision of a physician.

Subp. 2. **Supervision of nonenrolled vendor.** Except for a physician service provided in a physician directed clinic or a long-term care facility, a physician service by a physician's employee must be under the supervision of the provider in order to be eligible for payment under the medical assistance program.

Physician service in a physician directed clinic must be provided under the supervision of a physician who is on the premises and who is a provider.

Subp. 3. **Physician service in long-term care facility.** A physician service provided by a physician's employee in a long-term care facility is a covered service if provided under the direction of a physician who is a provider except as in items A to C.

A. The service is a certification made at the recipient's admission.

B. The service is to write a plan of care required by Code of Federal Regulations, title 42, part 456.

C. The service is a physician visit in a skilled nursing facility required by Code of Federal Regulations, title 42, section 405.1123 or a physician visit in an intermediate care facility required by Code of Federal Regulations, title 42, section 442.346. For purposes of this subpart, "physician visit" means the term specified in Code of Federal Regulations, title 42, sections 405.1123 and 442.346.

For purposes of this subpart, "under the direction of a physician who is a provider" means that the physician has authorized and is professionally responsible for the physician services performed by the physician's employee and has reviewed and signed the record of the service no more than five days after the service was performed.

Subp. 4. **Payment limitation on medically directed weight reduction program.** A weight reduction program requires prior authorization. It is a covered service only if the excess weight complicates a diagnosed medical condition or is life threatening. The weight reduction program must be prescribed and administered under the supervision of a physician.

Subp. 5. **Payment limitation on service to evaluate prescribed drugs.** Payment for a physician service to a recipient to evaluate the effectiveness of a drug prescribed in the recipient's plan of care is limited for each recipient to one service per week. The payment shall be made only for the evaluation of the effect of antipsychotic or antidepressant drugs.

Subp. 6. **Payment limitation on podiatry service furnished by a physician.** The limitations and exclusions applicable to podiatry services under part 9505.0350, subparts 2 and 3, apply to comparable services furnished by a physician.

Subp. 7. **Payment limitations on visits to long–term care facilities.** Payment for a physician visit to a long–term care facility is limited to once every 30 days per resident of the facility unless the medical necessity of additional visits is documented.

Subp. 8. **Payment limitation on laboratory service.** A laboratory service ordered by a physician is subject to the payment limitation of part 9505.0305, subpart 4. Furthermore, payment for a laboratory service performed in a physician's laboratory shall not exceed the amount paid for a similar service performed in an independent laboratory under part 9505.0305.

Subp. 9. **Payment limitation; more than one recipient on same day in same long–term care facility.** When a physician service is provided to more than one recipient who resides in the same long–term care facility by the same provider on the same day, payment for the provider's visit to the first recipient shall be according to part 9505.0445, item E, for the procedure code for the visit. The provider's visit on the same day to other recipients within the same long–term care facility must be billed with the multiple visit code established by the department. This subpart shall not apply to a provider's visit to provide an emergency service on the same day within the same long–term care facility if the emergency service could not have been scheduled consecutively with another recipient visit. If the provider visits other recipients in the same facility on the same day after providing an emergency service, the provider's visits must be billed with the multiple visit code.

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

A. artificial insemination;

B. procedure to reverse voluntary sterilization;

C. surgery primarily for cosmetic purposes;

D. services of a surgical assistant; and

E. inpatient hospital visits when the physician has not had face–to–face contact with the recipient.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0350 PODIATRY SERVICES.

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

A. "Foot hygiene" means the care of the foot to maintain a clean condition.

B. "Podiatry service" means a service provided by a podiatrist within the scope of practice defined in Minnesota Statutes, chapter 153.

Subp. 2. **Payment for debridement or reduction of nails, corns, and calluses.** Debridement or reduction of pathological toenails and of infected or eczematized corns or calluses shall be a covered service. The service shall be eligible for payment once every 60 days.

Subp. 3. **Limitation on payment for debridement or reduction of nails, corns, and calluses.** Payment for debridement or reduction of nonpathological toenails and of noninfected or noneczematized corns or calluses is limited to the conditions in items A to C.

A. The recipient has a diagnosis of diabetes mellitus, arteriosclerosis obliterans, Buerger's disease (thromboangitis obliterans), chronic thrombophlebitis, or peripheral neuropathies involving the feet. The service is eligible for payment only once every 60 days unless the service is required more often to treat ulcerations or abscesses complicated by diabetes or vascular insufficiency. Payment for treatment of ulcerations or abscesses complicated by diabetes or vascular insufficiency is limited to services that are medically necessary.

B. The recipient who is not a resident of a long–term care facility has a medical condition that physically prevents him or her from reducing the nail, corn, or callus. Examples of such a medical condition are blindness, arthritis, and malformed feet.

C. A podiatry visit charge must not be billed on the same date as the date of the service provided under item A or B.

Subp. 4. **Limitation on payment for podiatry service provided to a resident of a long–term care facility.** To be eligible for medical assistance payment, a podiatry service provided to a recipient who resides in a long–term care facility must result from a self–referral or a referral by a registered nurse or a licensed practical nurse who is employed by the facility or the recipient's family, guardian, or attending physician.

Subp. 5. **Payment limitation; more than one recipient on same day in same long–term care facility.** When a podiatry service is provided to more than one recipient who resides in the same long–term care facility by the same provider on the same day, payment for the provider's visit to the first recipient shall be according to part 9505.0445, item E, for the procedure code for the visit. The provider's visit on the same day to other recipients within the same long–term care facility must be billed with the multiple visit code established by the department. This subpart shall not apply to a provider's visit to provide an emergency service on the same day within the same long–term care facility if the emergency service could not have been scheduled consecutively with another recipient visit. If the provider visits other recipients in the same facility on the same day after providing an emergency service, the provider's visits must be billed with the multiple visit code.

Subp. 6. **Excluded services.** The podiatry services in items A to I are not eligible for payment under the medical assistance program:

A. stock orthopedic shoes; "stock orthopedic shoes" means orthopedic shoes other than those built to a person's specifications as prescribed by a podiatrist;

B. surgical assistants;

C. local anesthetics that are billed as a separate procedure;

D. operating room facility charges;

E. foot hygiene;

F. use of skin creams to maintain skin tone;

G. service not covered under Medicare, or service denied by Medicare because it is not medically necessary;

H. debridement or reduction of the nails, corns, or calluses except as in subparts 2 to 4; and

I. if the recipient is a resident of a long–term care facility, general foot care that can be reasonably performed by nursing staff of long–term care facilities. An example of general foot care is the reduction of toenails, corns, or calluses of a recipient who is not diagnosed as having a medical condition listed in subpart 3.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0353 PRENATAL CARE SERVICES.

Subpart 1. **Definitions.** For purposes of this part, the terms in items A to F have the meaning given them.

A. "At risk" refers to the recipient who requires additional prenatal care services because of a health condition that increases the probability of a problem birth or the delivery of a low birth weight infant. The term includes "at risk of poor pregnancy outcome" and "at high risk of poor pregnancy outcome."

B. "Prenatal care management" means the development, coordination, and ongoing evaluation of a plan of care for an at risk recipient by a physician or registered nurse on a one to one basis.

C. "Prenatal care services" refers to the total array of medically necessary health services provided to an at risk recipient during pregnancy. The services include those necessary for pregnancy and those additional services that are authorized in this part.

D. "Nutrition counseling" means services provided by a health care professional with specialized training in prenatal nutrition education to assess and to minimize the problems hindering normal nutrition in order to improve the recipient's nutritional status during pregnancy.

E. "Prenatal education" means services provided to recipients at risk of poor pregnancy outcomes by a health care professional with specialized training in instructing at risk recipients how to change their lifestyles, develop self care and parenting skills, and recognize warning signs of preterm labor and childbirth.

F. "Risk assessment" means identification of the medical, genetic, lifestyle, and psychosocial factors which identify recipients at risk of poor pregnancy outcomes.

Subp. 2. **Risk assessment.** To be eligible for medical assistance payment, a provider of prenatal care services shall complete a risk assessment for a recipient for whom the services are provided. The risk assessment must be completed at the recipient's first prenatal visit and on a form supplied by the department. The provider shall submit the completed form to the department when the provider submits the first claim for payment of services to the recipient.

Subp. 3. **Additional service for at risk recipients.** The services in items A to C shall be provided to a recipient if the recipient's risk assessment identifies the services as medically necessary because of her at risk status and if prior authorization is obtained.

A. Prenatal care management must include:

(1) development of an individual plan of care that addresses the recipient's specific needs related to the pregnancy;

(2) ongoing evaluation and, if appropriate, revision of the plan of care according to the recipient's needs related to pregnancy;

(3) assistance to the recipient in identifying, obtaining, and using services specified in the recipient's plan of care;

(4) monitoring, coordinating, and managing nutrition counseling and prenatal education services to assure that these are provided in the most economical, efficient, and effective manner.

B. Nutrition counseling includes:

(1) assessing the recipient's knowledge of nutritional needs in pregnancy;

(2) determining the areas of the recipient's dietary insufficiency;

(3) instructing the recipient about her nutritional needs during pregnancy;

(4) developing an individual nutrition plan, if indicated, including referral to community resources which assist in providing adequate nutrition.

C. Prenatal education includes:

(1) information and techniques for a healthy lifestyle during pregnancy, including stress management, exercise, and reduction or cessation of drug, alcohol, and cigarette use;

(2) instruction about preterm labor, warning signs of preterm labor, and appropriate methods to delay labor; and

(3) information about the childbirth process, parenting, and additional community resources as appropriate to the individual recipient.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0355 PREVENTIVE HEALTH SERVICES.

Subpart 1. **Definition; preventive health service.** For the purposes of this part, "preventive health service" means a health service provided to a recipient to avoid or minimize the occurrence of illness, infection, disability, or other health condition. Examples are diabetes education, cardiac rehabilitation, weight loss programs, and nutrition counseling that meet the criteria established in part 9505.0210.

Subp. 2. **Covered preventive health services.** To be eligible for medical assistance payment, a preventive health service must:

A. be provided to the recipient in person;

B. affect the recipient's health condition rather than the recipient's physical environment;

C. not be otherwise available to the recipient without cost as part of another program funded by a government or private agency;

D. not be part of another covered service;

E. be to minimize an illness, infection, or disability which will respond to treatment;

F. be generally accepted by the provider's professional peer group as a safe and effective means to avoid or minimize the illness; and

G. be ordered in writing by a physician and contained in the plan of care approved by the physician.

Subp. 3. **Payment limitations.** The services in items A and B are not eligible for medical assistance payment:

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

B. service dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0360 PRIVATE DUTY NURSING SERVICES.

Subpart 1. **Definition; private duty nursing service.** For purposes of this part, "private duty nursing service" means a nursing service ordered by a physician to provide individual and continual care to a recipient by a registered nurse or by a licensed practical nurse.

Subp. 2. **Prior authorization requirement.** Medical assistance payment for private duty nursing service provided to a recipient without prior authorization is limited to no more than 50 hours per month. Prior authorization is a condition of medical assistance payment for private duty nursing services to a recipient in excess of 50 hours per month and for private duty nursing services provided in a hospital or long-term care facility.

Subp. 3. **Covered service.** A private duty nursing service in items A to C is eligible for medical assistance payment:

A. service given to the recipient in his or her home, a hospital, or a skilled nursing facility if the recipient requires individual and continual care beyond the care available from a Medicare certified home health agency or personal care assistant or beyond the level of nursing care for which a long-term care facility or hospital is licensed and certified;

B. service given during medically necessary ambulance services; and

C. service that is required for the instruction or supervision of a personal care assistant under part 9505.0335. The service must be provided by a registered nurse.

Subp. 4. **Payment limitations.** To be eligible for medical assistance payment, a private duty nursing service must meet the conditions in items A to D.

A. The service must be ordered in writing by the recipient's physician.

B. The service must comply with the written plan of care approved by the recipient's physician.

C. The service may be provided only if:

(1) a home health agency, a skilled nursing facility, or a hospital is not able to provide the level of care specified in the recipient's plan of care; or

(2) a personal care assistant is not able to perform the level of care specified in the recipient's plan of care.

D. The service must be given by a registered nurse or licensed practical nurse who is not the recipient's legal guardian or related to the recipient as spouse, parent, or child whether by blood, marriage, or adoption.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624; L 1987 c 209 s 39*

9505.0365 PROSTHETIC AND ORTHOTIC DEVICES.

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

A. "Ambulatory aid" means a prosthetic or orthotic device that assists a person to move from place to place.

B. "Prosthetic or orthotic device" means an artificial device as defined by Medicare to replace a missing or nonfunctional body part, to prevent or correct a physical deformity or malfunction, or to support a deformed or weak body part.

C. "Physiatrist" means a physician who specializes in physical medicine or physical therapy and who is board certified by the American Board of Physical Medicine and Rehabilitation.

Subp. 2. **Eligible providers; medical supply agreement.** To be eligible for medical assistance payment, a supplier of a prosthetic or orthotic device must sign a performance agreement as defined in part 9505.0175, subpart 32.

Subp. 3. **Payment limitation; ambulatory aid.** To be eligible for medical assistance payment, an ambulatory aid must be prescribed by a physician who is knowledgeable in orthopedics or physiatrics or by a physician in consultation with an orthopedist, physiatrist, physical therapist, or occupational therapist, or by a podiatrist.

Prior authorization of an ambulatory aid is required for an aid that costs in excess of the limits specified in the provider's performance agreement.

Subp. 4. [Repealed, 17 SR 2042]

Subp. 5. **Payment limitation; general.** The cost of repair to a prosthetic or orthotic device that is rented or purchased by the medical assistance program under a warranty is not eligible for medical assistance payment if the repair is covered by warranty.

Subp. 6. **Excluded prosthetic and orthotic devices.** The prosthetic and orthotic devices in items A to J are not eligible for medical assistance payment:

A. a device for which Medicare has denied the claim as not medically necessary;

B. a device that is not medically necessary for the recipient;

C. a device, other than a hearing aid, that is provided to a recipient who is an inpatient or resident of a long–term care facility and that is billed directly to medical assistance except as in part 9505.0310, subpart 2;

D. repair of a rented device;

E. routine, periodic service of a recipient's device owned by a long–term care facility;

F. a device whose primary purpose is to serve as a convenience to a person caring for the recipient;

G. a device that is not received by the recipient;

H. a device that serves to address social and environment factors and that does not directly address the recipient's physical or mental health;

I. a device that is supplied to the recipient by the physician who prescribed the device or by the consultant to the physician in subpart 3; and

J. a device that is supplied to the recipient by a provider who is an affiliate of the physician who prescribes the device for the recipient or of the consultant to the physician as in subpart 3. For purposes of this item, "affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with the referring physician.

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 17 SR 2042*

9505.0380 PUBLIC HEALTH CLINIC SERVICES.

Subpart 1. **Definition.** "Public health clinic services" means a health service provided by or under the supervision of a physician in a clinic that is a department of, or operates under the direct authority of a unit of government.

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

A. physician services as in part 9505.0345;

B. preventive health services as in part 9505.0355;

C. family planning services as in part 9505.0280;

D. prenatal care services as in part 9505.0353;

E. dental services as in part 9505.0270; and

F. early and periodic screening diagnosis and treatment as in part 9505.0275.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0385 REHABILITATION AGENCY SERVICES.

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

A. "Physical impairment" means physical disabilities including those physical disabilities that result in cognitive impairments.

B. "Rehabilitation agency" means a provider that is certified by Medicare to provide restorative therapy and specialized maintenance therapy as defined in part 9505.0390, subpart 1, items J and K, and to provide social or vocational adjustment services under the Code of Federal Regulations, title 42, section 405.1702, paragraph h.

Subp. 2. **Covered services.** To be eligible for medical assistance payment, the services specified in items A and B that are provided by a rehabilitation agency must be ordered by a physician, must be related to the recipient's physical impairment, and must be designed to improve or maintain the functional status of a recipient with a physical impairment:

A. physician services under part 9505.0345; and

B. rehabilitative and therapeutic services as in part 9505.0390.

Subp. 3. **Eligibility as rehabilitation agency service; required site of service.** To be eligible for medical assistance payment, a rehabilitation agency service must be provided at a site that has been surveyed by the Minnesota Department of Health and certified according to Medicare standards; or at a site that meets the standards of the State Fire Marshal as documented in the provider's records; or at the recipient's residence. If the federal government denies reimbursement for services at non–Medicare certified sites, because the sites are not Medicare certified, then the eligibility for rehabilitation agency services shall be restricted to sites which meet the Medicare certification standards.

Subp. 4. **Social and vocational adjustment service provided by rehabilitation agency.** A social or vocational adjustment service provided by a rehabilitation agency must meet the requirements of Code of Federal Regulations, title 42, section 405.1702, must be provided as an unreimbursed adjunct to the covered services specified in subparts 2 and 3, and is not eligible for payment on a fee for service basis.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0386 COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES.

Subpart 1. **Definition.** For purposes of this part and part 9505.0410, "comprehensive outpatient rehabilitation facility" means a nonresidential facility that is established and oper-

ated exclusively to provide diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons, at a single fixed location, by or under the direction of a physician and that meets the conditions of participation specified in Code of Federal Regulations, title 42, section 485, subpart B.

Subp. 2. **Eligibility for payment.** To be eligible for medical assistance payment as a provider of rehabilitative and therapeutic services, a comprehensive outpatient rehabilitation facility must meet the requirements of parts 9505.0385 and 9505.0390. Additionally, mental health services provided by the comprehensive outpatient rehabilitation facility according to part 9505.0323 shall be eligible for medical assistance payment.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0390 REHABILITATIVE AND THERAPEUTIC SERVICES.

Subpart 1. **Definitions.** For purposes of parts 9505.0390 to 9505.0392 and 9505.0410 to 9505.0412, the following terms have the meanings given them in this part.

A. "Audiologist" means a person who has a current certificate of clinical competence in audiology from the American Speech–Language–Hearing Association and, when it is applicable, who holds the specific state licensure and registration requirements for the services the person provides.

B. "Direction" means, notwithstanding any other definition of direction in parts 9505.0170 to 9505.0475, the actions of a physical or occupational therapist who instructs the physical therapist assistant or the occupational therapy assistant in specific duties to be performed, monitors the provision of services as the therapy assistants provide the service, is on the premises not less than every sixth treatment session of each recipient when treatment is provided by a physical therapist assistant or occupational therapy assistant, and meets the other supervisory requirements of parts 5601.1500 and 5601.1600.

C. "Functional status" means the ability of the person to carry out the tasks associated with daily living.

D. "Occupational therapist" means a person who is currently registered by the American Occupational Therapy Association as an occupational therapist.

E. "Occupational therapy assistant" means a person who has an associate degree in occupational therapy and is currently certified by the American Occupational Therapy Certification Board as an occupational therapy assistant.

F. "Physical therapist" means a person who is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent and, when it is applicable, licensed by the state.

G. "Physical therapist assistant" means a person who is qualified as specified in part 5601.0100, subpart 3.

H. "Rehabilitative and therapeutic services" means restorative therapy, specialized maintenance therapy, and rehabilitative nursing services.

I. "Rehabilitative nursing services" means rehabilitative nursing care as specified in part 4655.5900, subparts 2 and 3.

J. "Restorative therapy" means a health service that is specified in the recipient's plan of care by a physician and that is designed to restore the recipient's functional status to a level consistent with the recipient's physical or mental limitations.

K. "Specialized maintenance therapy" means a health service that is specified in the recipient's plan of care by a physician, that is necessary for maintaining a recipient's functional status at a level consistent with the recipient's physical or mental limitations, and that may include treatments in addition to rehabilitative nursing services.

L. "Speech–language pathologist" means a person who has a certificate of clinical competence in speech–language pathologies from the American Speech–Language–Hearing Association and, when it is applicable, meets the specific state licensure and registration requirements for the services the person provides.

Subp. 2. **Covered service; occupational therapy and physical therapy.** To be eligible for medical assistance payment as a rehabilitative and therapeutic service, occupational therapy and physical therapy must be:

A. prescribed by a physician;

B. provided by a physical or occupational therapist or by a physical therapist assistant or occupational therapy assistant who, as appropriate, is under the direction of a physical or occupational therapist;

C. provided to a recipient whose functional status is expected by the physician to progress toward or achieve the objectives in the recipient's plan of care within a 60–day period; and

D. specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's attending physician at least once every 60 days unless the service is a Medicare covered service and is to a recipient who also is eligible for Medicare. If the service is to a recipient who also is eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare.

Subp. 3. **Covered service; speech–language service.** To be eligible for medical assistance payment as a rehabilitative and therapeutic service, a speech–language service must be:

A. provided upon written referral by a physician or in the case of a resident of a long–term care facility, on the written order of a physician as specified in Code of Federal Regulations, title 42, section 483.45;

B. provided by a speech–language pathologist. A person completing the clinical fellowship year required for certification as a speech–language pathologist may provide speech–language services under the supervision of a speech–language pathologist but shall not be eligible to be enrolled as a provider under part 9505.0195;

C. provided to a recipient whose functional status is expected by the physician to progress toward or achieve the objectives in the recipient's plan of care within a 60–day period; and

D. specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's attending physician at least once every 60 days unless the service is a Medicare covered service and is to a recipient who also is eligible for Medicare. If the service is to a recipient who also is eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare.

Subp. 4. **Covered service; audiology.** To be eligible for medical assistance payment as a rehabilitative and therapeutic service, an audiology service must be:

A. provided upon written referral by a physician;

B. provided by an audiologist. A person completing the clinical fellowship year required for certification as an audiologist may provide audiological services under the supervision of an audiologist but shall not be enrolled as a provider under part 9505.0195;

C. provided to a recipient whose functional status is expected by the physician to progress toward or achieve the objectives in the recipient's plan of care within a 60–day period; and

D. specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's attending physician at least once every 60 days unless the service is a Medicare covered service and is to a recipient who also is eligible for Medicare. If the service is to a recipient who also is eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare.

Subp. 5. **Covered service; specialized maintenance therapy.** To be eligible for medical assistance payment, specialized maintenance therapy must be:

A. provided by a physical therapist, physical therapy assistant, occupational therapist, or occupational therapy assistant;

B. specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's physician at least once every 60 days unless the service is a Medicare cov-

ered service and is to a recipient who also is eligible for Medicare. If the service is to a recipient who also is eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare; and

C. provided to a recipient who cannot be treated only through rehabilitative nursing services because of a condition in subitems (1) to (5):

(1) spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care;

(2) a chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance, movement patterns, activities of daily living, or positioning necessary for completion of the recipient's activities of daily living;

(3) an orthopedic condition that may lead to physiological deterioration and require therapy intervention by an occupational therapist or a physical therapist to maintain strength, joint mobility, and cardiovascular function;

(4) chronic pain that interferes with functional status and is expected by the physician to respond to therapy; or

(5) skin breakdown that requires a therapy procedure other than a rehabilitative nursing service.

Subp. 6. **Payment for rehabilitative nursing service in long–term care facility.** Medical assistance payment for a rehabilitative nursing service in a long–term care facility is subject to the conditions in parts 9549.0010 to 9549.0080 and 9553.0010 to 9553.0080.

Subp. 7. **Payment limitation; therapy assistants and aides.** To be eligible for medical assistance payment on a fee for service basis, health services provided by therapy assistants must be provided under the direction of a physical or occupational therapist. Services of a therapy aide in a long–term care facility are not separately reimbursable on a fee for service basis. Services of a therapy aide in a setting other than a long–term care facility are not reimbursable.

Subp. 8. **Excluded restorative and specialized maintenance therapy services.** Restorative and specialized maintenance therapy services in items A to K are not eligible for medical assistance payment:

A. physical or occupational therapy that is provided without a prescription of a physician;

B. speech–language or audiology service that is provided without a written referral from a physician;

C. services provided by a long–term care facility that are included in the costs covered by the per diem payment under parts 9549.0010 to 9549.0080 and 9553.0010 to 9553.0080 including:

(1) services for contractures that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long–term care facility;

(2) ambulation of a recipient who has an established functional gait pattern;

(3) services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be managed by routine nursing measures;

(4) services for activities of daily living when performed by the therapist, therapist assistant, or therapy aide; and

(5) bowel and bladder retraining programs;

D. arts and crafts activities for the purpose of recreation;

E. service that is not medically necessary;

F. service that is not documented in the recipient's health care record;

G. service specified in a plan of care that is not reviewed, and revised as medically necessary, by the recipient's attending physician as required in subparts 2 to 5;

H. service that is not designed to improve or maintain the functional status of a recipient with a physical impairment;

I. service that is not part of the recipient's plan of care;

J. service by more than one provider of the same type of rehabilitative and therapeutic services, for the same diagnosis unless the service is provided by a school district as specified in the recipient's individualized education plan under Minnesota Statutes, section 256B.0625, subdivision 26; and

K. service that is provided by a rehabilitation agency as defined in part 9505.0385, subpart 1, item B, and that takes place in a sheltered workshop, in a developmental achievement center as defined in part 9525.1210, subpart 8, or service at a residential or group home which is an affiliate of the rehabilitation agency.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0391 THERAPISTS ELIGIBLE TO ENROLL AS PROVIDERS.

A physical therapist, an occupational therapist, an audiologist, or a speech–language pathologist is eligible to enroll as a provider if the therapist complies with the requirements of part 9505.0195 and maintains an office at the therapist's or pathologist's own expense. Additionally, a physical therapist or occupational therapist must be certified by Medicare. However, a service provided by an independently enrolled therapist or pathologist is not eligible for medical assistance payment under the therapist's or pathologist's provider number on a fee for service basis if the service was provided:

A. while the therapist or pathologist functioned as an employee of another provider; or

B. by another therapist or pathologist employed by the independently enrolled therapist unless the employee is a speech–language pathologist or an audiologist completing a clinical fellowship year.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0392 COMPLIANCE WITH MEDICARE REQUIREMENTS.

Notwithstanding requirements of parts 9505.0385, 9505.0386, 9505.0390, and 9505.0391, a rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements shall not be eligible for medical assistance reimbursement.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0395 RURAL HEALTH CLINIC SERVICES.

Subpart 1. **Definition.** "Rural health clinic service" means a health service provided in a clinic certified under Code of Federal Regulations, title 42, part 491.

Subp. 2. **Covered services.** All health services provided by a rural health clinic are covered services within the limitations applicable to the same services under parts 9505.0170 to 9505.0475 if the rural health clinic's staffing requirements and written policies governing health services provided by personnel other than a physician are in compliance with Code of Federal Regulations, title 42, part 491.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0405 VISION CARE SERVICES.

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

A. "Complete vision examination" means diagnostic procedures to determine the health of the eye and the refractive status of the eye, and the need for eyeglasses or a change in eyeglasses.

B. "Dispensing services" means the technical services necessary for the design, fitting, and maintenance of eyeglasses as prescribed by an optometrist or physician skilled in diseases of the eye.

C. "Eyeglasses" means lenses, frames for the lenses if necessary, and other aids to vision prescribed by an optometrist or physician skilled in diagnosing and treating diseases of the eye.

D. "Optician" means a supplier of eyeglasses to a recipient as prescribed by the optometrist or medical doctor.

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

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

G. "Vision care services" means a prescriptive, diagnostic, or therapeutic service provided by and within the scope of practice of an optometrist or physician skilled in diseases of the eye and the dispensing services provided by an optician, optometrist, or physician in fabricating or dispensing eyeglasses or other aids to vision that an optometrist or physician skilled in diseases of the eye prescribes for a recipient.

Subp. 2. **Payment limitations.** Payment for a recipient's vision care services provided under the medical assistance program is limited as in items A to D.

A. One complete vision examination in a 24 month period unless a request for prior authorization is approved for an additional complete vision examination.

B. One pair of eyeglasses or one replacement of each lens in the eyeglasses in a 24 month period unless a pair of eyeglasses or a replacement of a lens in the eyeglasses that is in excess of this limit obtains prior authorization. Eyeglasses or a change of eyeglasses must be shown to be medically necessary by a complete vision examination.

C. Replacement of a pair of eyeglasses or replacement of a lens in the eyeglasses in excess of the limit in item B if the replacement is necessary because the eyeglasses were misplaced or stolen or a lens or pair of eyeglasses was damaged due to circumstances beyond the recipient's control and prior authorization is obtained. The recipient's degree of physical and mental impairment shall be considered in determining whether the circumstances were beyond the recipient's control.

D. A request for prior authorization of eyeglasses required under item A or B must be approved or denied no later than one month after the department has received the information necessary to document the request.

Subp. 3. **Payment limitation; more than one recipient on same day in same long–term care facility.** When a vision care service is provided by the same provider to more than one recipient who resides in the same long–term care facility on the same day, payment for the provider's visit to the first recipient shall be according to part 9505.0445, item E, for the procedure code for the visit. The provider's visit on the same day to other recipients within the same long–term care facility must be billed with the multiple visit code established by the department. This subpart shall not apply to a provider's visit to provide an emergency service on the same day within the same long–term care facility if the emergency service could not have been scheduled consecutively with another recipient visit. If the provider visits other recipients in the same facility on the same day after providing an emergency service, the provider's visits must be billed with the multiple visit code.

Subp. 4. **Excluded services.** The following vision care services are not eligible for payment under the medical assistance program.

A. Services provided for cosmetic reasons. Examples are:

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

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

B. Dispensing services related to noncovered services.

C. Fashion tints that do not absorb ultraviolet or infrared wave lengths.

D. Protective coating for plastic lenses.

E. Edge and antireflective coating of lenses.

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

G. Replacement of lenses or frames, if the replacement is not medically necessary.

H. Oversize lenses which exceed the lens size specified in the competitive bidding contract established under Minnesota Statutes, chapter 16B.

I. Invisible bifocals or progressive bifocals.

J. A vision care service for which a required prior authorization was not obtained.

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

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

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0410 LONG-TERM CARE FACILITIES; REHABILITATIVE AND THERAPEUTIC SERVICES TO RESIDENTS.

Subpart 1. **Eligible providers.** The providers in items A to F are eligible for medical assistance payment on a fee for service basis for restorative therapy and specialized maintenance therapy that is provided according to part 9505.0390 and that is provided at the site of a long-term care facility to a recipient residing in the long-term care facility:

A. a long-term care facility as defined in part 9505.0175, subpart 23;

B. a rehabilitation agency as defined in part 9505.0385;

C. a comprehensive outpatient rehabilitation facility as defined in part 9505.0386;

D. a physical therapist as defined in part 9505.0390;

E. an occupational therapist as defined in part 9505.0390; and

F. a speech-language pathologist or audiologist as defined in part 9505.0390, subpart 1, item E.

Subp. 2. **Payment limitation.** To be eligible for medical assistance payment, rehabilitative and therapeutic services provided to recipients residing in a long-term care facility must comply with the requirements of parts 9505.0170 to 9505.0475.

Subp. 3. **Payment for restorative therapy and specialized maintenance therapy.** Medical assistance payment for restorative therapy and specialized maintenance therapy may be made according to part 9505.0445, item O, or as provided in parts 9549.0010 to 9549.0080 or 9553.0010 to 9553.0080, or as specified in the contract between the department and a prepaid health plan according to part 9505.0285.

Subp. 4. **Payment for rehabilitative nursing services.** Medical assistance payment for rehabilitative nursing services shall be as provided in parts 9549.0010 to 9549.0080 or 9553.0010 to 9553.0080, as applicable. However, payment for a rehabilitative nursing service shall not be made on a fee for service basis.

Subp. 5. **Reporting of fees for service by long-term care facility.** A long-term care facility that receives medical assistance payment on a fee for service basis for the provision of restorative and specialized maintenance therapy to a resident shall report the therapy income in accordance with parts 9549.0010 to 9549.0080 or 9553.0010 to 9553.0080, as applicable. This subpart applies to medical assistance payments made to the long-term care facility for therapy services provided by an employee or by a related organization. For purposes of this subpart, "related organization" has the meaning given it in Minnesota Statutes, section 256B.433, subdivision 3, paragraph (b).

Subp. 6. **Prohibited practices.** If medical assistance payment is made to a provider other than a long-term care facility for restorative therapy and specialized maintenance therapy, the long-term care facility in which the recipient resides must not request or receive payment from the provider in excess of the limit on charges specified in Minnesota Statutes, section 256B.433, subdivision 3, paragraph (c).

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0411 LONG-TERM CARE FACILITIES; REHABILITATIVE AND THERAPEUTIC SERVICES TO NONRESIDENTS.

Rehabilitative and therapeutic services provided by and at the site of a long-term care facility to a recipient who is not a resident of a long-term care facility are eligible for medical assistance payment if the facility is certified by Medicare as an outpatient therapy provider, under Code of Federal Regulations, title 42, part 405, subpart Q, if the service is a covered service, and if the requirements of parts 9505.0390 to 9505.0412 are met.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0412 REQUIRED DOCUMENTATION OF REHABILITATIVE AND THERAPEUTIC SERVICES.

A rehabilitative or therapeutic service provided under parts 9505.0385, 9505.0386, 9505.0390, 9505.0391, 9505.0395, 9505.0396, 9505.0410, and 9505.0411 must be documented as specified in items A to D.

A. The service must be specified in the recipient's plan of care that is reviewed and revised as medically necessary by the recipient's physician at least once every 60 days. However, if the service is to a recipient who is also eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by a physician or by the physician delegate as required by Medicare.

B. The recipient's plan of care must state:

(1) the recipient's medical diagnosis and any contraindications to treatment;

(2) a description of the recipient's functional status;

(3) the objectives of the rehabilitative and therapeutic service; and

(4) a description of the recipient's progress toward the objectives in subitem (3).

C. The recipient's plan of care must be signed by the recipient's physician.

D. The record of the recipient's service must show:

(1) the date, type, length, and scope of each rehabilitative and therapeutic service provided to the recipient;

(2) the name or names and titles of the persons providing each rehabilitative and therapeutic service;

(3) the name or names and titles of the persons supervising or directing the provision of each rehabilitative and therapeutic service; and

(4) a statement, every 30 days, by the therapist providing or supervising the services, other than an initial evaluation, that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the recipient in accordance with Minnesota Statutes, section 256B.433, subdivision 2.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0415 LONG-TERM CARE FACILITIES; LEAVE DAYS.

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

A. "Certified bed" means a bed certified under title XIX of the Social Security Act.

B. "Discharge" or "discharged" refers to the status of a recipient as defined in part 9549.0051, subpart 7, as published in the State Register, December 1, 1986, volume 11, number 22.

C. "Hospital leave" means the status of a recipient who has been transferred from the long-term care facility to an inpatient hospital for medically necessary health care, with the expectation the recipient will return to the long-term care facility.

D. "Leave day" means any calendar day during which the recipient leaves the facility and is absent overnight, and all subsequent, consecutive calendar days. An overnight

absence from the facility of less than 23 hours does not constitute a leave day. Nevertheless, if the recipient is absent from the facility to participate in active programming of the facility under the personal direction and observation of facility staff, the day shall not be considered a leave day regardless of the number of hours of the recipient's absence. For purposes of this item, "calendar day" means the 24 hour period ending at midnight.

E. "Reserved bed" means the same bed that a recipient occupied before leaving the facility for hospital leave or therapeutic leave or an appropriately certified bed if the recipient's physical condition upon returning to the facility prohibits access to the bed he or she occupied before the leave.

F. "Therapeutic leave" means the absence of a recipient from a long–term care facility, with the expectation of the recipient's return to the facility, to a camp meeting applicable licensure requirements of the Minnesota Department of Health, a residential setting other than a long–term care facility, a hospital, or other entity eligible to receive federal, state, or county funds to maintain a recipient. Leave for a home visit or a vacation is a therapeutic leave.

Subp. 2. **Payment for leave days.** A leave day is eligible for payment under medical assistance, subject to the limitations of this part. The leave day must be for hospital leave or therapeutic leave of a recipient who has not been discharged from the long–term care facility. A reserved bed must be held for a recipient on hospital leave or therapeutic leave.

Subp. 3. **Hospital leave.** A hospital leave for which a leave day is claimed must comply with the conditions in items A to C if the leave day is to be eligible for medical assistance payment.

A. The recipient must have been transferred from the long–term care facility to a hospital.

B. The recipient's health record must document the date the recipient was transferred to the hospital and the date the recipient returned to the long–term care facility.

C. The leave days must be reported on the invoice submitted by the long–term care facility.

Subp. 4. **Therapeutic leave.** A therapeutic leave for which a leave day is claimed must comply with the conditions in items A and B if the leave day is to be eligible for payment under medical assistance.

A. The recipient's health care record must document the date and the time the recipient leaves the long–term care facility and the date and the time of return.

B. The leave days must be reported on the invoice submitted by the long–term care facility.

Subp. 5. **Payment limitations on number of leave days for hospital leave.** Payment for leave days for hospital leave is limited to 18 consecutive days for each separate and distinct episode of medically necessary hospitalization. For the purpose of this part "separate and distinct episode" means:

A. the occurrence of a health condition that is an emergency;

B. the occurrence of a health condition which requires inpatient hospital services but is not related to a condition which required previous hospitalization and was not evident at the time of discharge; or

C. the repeat occurrence of a health condition that is not an emergency but requires inpatient hospitalization at least two calendar days after the recipient's most recent discharge from a hospital.

Subp. 6. **Payment limitations on number of leave days for therapeutic leave.** Payment for leave days for therapeutic leave is limited to the number of days as in items A to D:

A. recipients receiving skilled nursing facility services as provided in part 9505.0420, subpart 2, 36 leave days per calendar year;

B. recipients receiving intermediate care facility services as provided in part 9505.0420, subpart 3, 36 leave days per calendar year;

C. recipients receiving intermediate care facility, mentally retarded services as provided in part 9505.0420, subpart 4, 72 leave days per calendar year;

D. recipients residing in a long–term care facility that has a license to provide services for the physically handicapped as provided in parts 9570.2000 to 9570.3600, 72 leave days per calendar year.

Subp. 7. **Payment limitation on billing for leave days.** Payment for leave days for hospital leave and therapeutic leave shall be subject to the limitation as in items A to C. For purposes of this subpart, a reserved bed is not a vacant bed when determining occupancy rates and eligibility for payment of a leave day.

A. Long–term care facilities with 25 or more licensed beds shall not receive payment for leave days in a month for which the average occupancy rate of licensed beds is 93 percent or less.

B. Long–term care facilities with 24 or fewer licensed beds shall not receive payment for leave days if a licensed bed has been vacant for 60 consecutive days prior to the first leave day of a hospital leave or therapeutic leave.

C. The long–term care facility charge for a leave day for a recipient must not exceed the charge for a leave day for a private paying resident. "Private paying resident" has the meaning given in part 9549.0020, subpart 35.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0420 LONG–TERM CARE FACILITY SERVICES.

Subpart 1. **Covered service.** Services provided to a recipient in a long–term care facility are eligible for medical assistance payment subject to the provisions in subparts 2, 3, and 4, and in parts 9505.2250 to 9505.2380, 9549.0010 to 9549.0080, and 9553.0010 to 9553.0080.

Subp. 2. **Payment limitation; skilled nursing care facility.** The medical assistance program shall pay the cost of care of a recipient who resides in a skilled nursing facility when the recipient requires:

A. daily care ordered by the recipient's attending physician on a 24 hour basis; and one of the following:

B. nursing care as defined in Minnesota Statutes, section 144A.01, subdivision 6, that can be safely performed only by or under the direction of a registered nurse in compliance with parts 4655.0090 to 4655.9900; or

C. rehabilitative and therapeutic services as in part 9500.1070, subpart 13.

Subp. 3. **Payment limitation; intermediate care facility, levels I and II.** The medical assistance program shall pay the cost of care of a recipient who resides in a facility certified as an intermediate care facility, level I or II by the Department of Health when the recipient requires:

A. daily care ordered by the recipient's attending physician to be provided in compliance with parts 4655.0090 to 4655.9900;

B. ongoing care and services because of physical or mental limitations that can be appropriately cared for only in an intermediate care facility.

Subp. 4. **Payment limitation; intermediate care facility, mentally retarded.** The medical assistance program shall pay the cost of care of a recipient who resides in a facility certified as an intermediate care facility for mentally retarded persons licensed under Minnesota Statutes, sections 144.50 to 144.56, or chapter 144A and licensed for program services under parts 9525.0210 to 9525.0430 when the recipient:

A. meets the admission criteria specified in Code of Federal Regulations, title 42, section 442.418;

B. requires care under the management of a qualified mental retardation professional as defined by Code of Federal Regulations, title 42, section 442.401; and

C. requires active treatment as defined in Code of Federal Regulations, title 42, section 435.1009.

Subp. 5. **Exemptions from the federal utilization control requirements.** A skilled nursing facility, an intermediate care facility, or intermediate care facility for mentally retarded persons that is operated, listed, and certified as a Christian Science sanatorium by the

First Church of Christ, Scientist, of Boston, Massachusetts, is not subject to the federal regulations for utilization control in order to receive medical assistance payments for the cost of recipient care.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0425 RESIDENT FUND ACCOUNTS.

Subpart 1. **Use of resident fund accounts.** A resident who resides in a long–term care facility may choose to deposit his or her funds including the personal needs allowance established under Minnesota Statutes, section 256B.35, subdivision 1, in a resident fund account administered by the facility.

Subp. 2. **Administration of resident fund accounts.** A long–term care facility must administer a resident fund account as in items A to I and parts 4655.4100 to 4655.4170.

A. The facility must credit to the account all funds attributable to the account including interest and other forms of income.

B. The facility must not commingle resident funds with the funds of the facility.

C. The facility must keep a written record of the recipient's resident fund account. The written record must show the date, amount, and source of a deposit in the account, and the date and amount of a withdrawal from the account. The facility must record contemporaneously a deposit or withdrawal and within five working days after the deposit or withdrawal must update the recipient's individual written record to reflect the transaction.

D. The facility shall require a recipient who withdraws $10 or more at one time to sign a receipt for the withdrawal. The facility shall retain the receipt and written records of the account until the account is subjected to the field audit required under Minnesota Statutes, section 256B.35, subdivision 4. A withdrawal of $10 or more that is not documented by a receipt must be credited to the recipient's account. Receipts for the actual item purchased for the recipient's use may substitute for a receipt signed by the recipient.

E. The facility must not charge the recipient a fee for administering the recipient's account.

F. The facility must not solicit donations or borrow from a resident fund account.

G. The facility shall report and document to the local agency a recipient's donation of money to the facility when the donation equals or exceeds the statewide average monthly per person rate for skilled nursing facilities determined under parts 9549.0010 to 9549.0080. This documentation may be audited by the commissioner.

H. The facility must not use resident funds as collateral for or payment of any obligations of the facility.

I. Payment of any funds remaining in a recipient's account when the recipient dies or is discharged shall be treated under part 4655.4170.

Subp. 3. **Limitations on purpose for which resident fund account funds may be used.** Except as otherwise provided in this part, funds in a recipient's resident fund account may not be used to purchase the materials, supplies, or services specified in items A to F. Nevertheless, the limitations in this subpart do not prohibit the recipient from using his or her funds to purchase a brand name supply or other furnishing or item not routinely supplied by the long–term care facility.

A. Medical transportation as provided in part 9505.0315.

B. The initial purchase or the replacement purchase of furnishings or equipment required as a condition of certification as a long–term care facility.

C. Laundering of the recipient's clothing as provided in part 9549.0040, subpart 2.

D. Furnishings or equipment which are not requested by the recipient for his or her personal convenience.

E. Personal hygiene items necessary for daily personal care. Examples are bath soap, shampoo, toothpaste, toothbrushes, dental floss, shaving cream, nonelectric shaving razor, and facial tissues.

F. Over the counter drugs or supplies used by the recipient on an occasional, as needed basis that have not been prescribed for long–term therapy of a medical condition. Ex-

amples of over the counter drugs or supplies are aspirin, aspirin compounds, acetaminophen, antacids, antidiarrheals, cough syrups, rubbing alcohol, talcum powder, body lotion, petrolatum jelly, lubricating jelly, and mild antiseptic solutions.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0430 HEALTH CARE INSURANCE PREMIUMS.

The medical assistance program shall pay the cost of a premium to purchase health insurance coverage for a recipient when the premium purchases coverage limited to health services and the department approves the health insurance coverage as cost effective.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0440 MEDICARE BILLING REQUIRED.

A provider shall comply with the Medicare billing requirements in items A and B.

A. A provider who is authorized to participate in Medicare shall bill Medicare before billing medical assistance for services covered by Medicare unless the provider has reason to believe that a service covered by Medicare will not be eligible for payment. A provider shall not be required to take an action that may jeopardize the limitation on liability under Medicare as specified in Code of Federal Regulations, title 42, section 405.195. However, the provider must document that, because of recent claim experiences with Medicare or because of written communication from Medicare, coverage is not available.

B. A provider specified in item A shall accept Medicare assignment if the medical assistance payment rate for the service to the recipient is at the same rate or less than the Medicare payment.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0445 PAYMENT RATES.

The maximum payment rates for health services established as covered services by parts 9505.0170 to 9505.0475 shall be as in items A to U.

A. For skilled nursing care facility services, the rates shall be as established in parts 9549.0010 to 9549.0080 and 9549.0050 to 9549.0059 as published in the State Register, December 1, 1986, volume 11, number 22, pages 991 to 1004.

B. For intermediate care facility services, the rates shall be as established in parts 9549.0010 to 9549.0080 and 9549.0050 to 9549.0059 as published in the State Register, December 1, 1986, volume 11, number 22, pages 991 to 1004.

C. For services of an intermediate care facility for persons with mental retardation or related conditions, the rates shall be as established in parts 9553.0010 to 9553.0080.

D. For hospital services, the rates shall be as established in parts 9500.1090 to 9500.1155.

E. For audiology services, chiropractic services, dental services, mental health center services, physical therapy, physician services, podiatry services, psychological services, speech pathology services, and vision care, the rate shall be the lowest of the provider's submitted charge, the provider's individual customary charge submitted during the calendar year specified in the legislation governing maximum payment rates, or the 50th percentile of the usual and customary fees based upon billings submitted by all providers of the service in the calendar year specified in legislation governing maximum payment rates.

F. For clinic services other than rural health clinic services, the rate shall be the lowest of the provider's submitted charge, the provider's individual customary charge submitted during the calendar year specified in the legislation governing maximum payment rates, the 50th percentile of the usual and customary fees based upon billings submitted by all providers of the service in the calendar year specified in legislation governing maximum payment rates, or Medicare payment amounts for comparable services under comparable circumstances.

G. For outpatient hospital services excluding emergency services and excluding facility fees for surgical services, the rate shall be the lowest of the provider's submitted charge, the provider's individual customary charge submitted in the calendar year specified in legislation governing maximum payment rates, the 50th percentile of the usual and customary fees based upon billings submitted by all providers of the service in the calendar year specified in legislation governing maximum payment rates, or Medicare payment amounts for comparable services under comparable circumstances.

H. For facility services which are performed in an outpatient hospital or an ambulatory surgical center, the rate shall be the lower of the provider's submitted charge or the standard flat rate under Medicare reimbursement methods for facility services provided by ambulatory surgical centers. The standard flat rate shall be the rate based on Medicare costs reported by ambulatory surgical centers for the calendar year in legislation governing maximum payment rates.

I. For facility fees for emergency outpatient hospital services, the rate shall be the provider's individual usual and customary charge for facility services based on the provider's costs in calendar year 1983. The calendar year in this item shall be revised as necessary to be consistent with calendar year revisions enacted after October 12, 1987, in legislation governing maximum payments for providers named in item D.

J. For home health agency services, the rate shall be the lower of the provider's submitted charge or the Medicare cost per visit limits based on Medicare cost reports submitted by free standing home health agencies in the Minneapolis and Saint Paul area in the calendar year specified in legislation governing maximum payment rates for services in item E.

K. For private duty nursing services, the rate shall be the lower of the provider's submitted charge or the maximum rate established by the legislature. The maximum rate shall be adjusted annually on July 1 to reflect the annual percentage increase reported in the most recent Consumer Price Index (Urban) for the Minneapolis – Saint Paul area new series index (1967=100) as published by the Bureau of Labor Statistics, United States Department of Labor. The Consumer Price Index (Urban) is incorporated by reference and is available from the Minitex interlibrary loan system. It is subject to frequent change.

L. For personal care assistant services, the rate shall be the lower of the provider's submitted charge or the maximum rate established by the department. The maximum rates shall be adjusted annually on July 1 to reflect the annual percentage increase reported in the most recent Consumer Price Index (Urban) for the Minneapolis–Saint Paul area as specified in item K.

M. For EPSDT services, the rate shall be the lower of the provider's submitted charge or the 75th percentile of all complete EPSDT screening charges submitted for complete EPSDT screenings during the prior state fiscal year, July 1 to the following June 30. The adjustment necessary to reflect the 75th percentile shall be effective annually on October 1.

N. For pharmacy services, the rates shall be as established in part 9505.0340, subpart 7.

O. For rehabilitation agency services, the rate shall be the lowest of the provider's submitted charges, the provider's individual and customary charge submitted during the calendar year specified in the legislation governing maximum payment rates for providers in item D, or the 50th percentile of the usual and customary fees based upon billings submitted by all providers of the service in the calendar year specified in legislation governing maximum payment rates for providers in item D.

P. For rural health clinic services, reimbursement shall be according to the methodology in Code of Federal Regulations, title 42, section 447.371. If a rural health clinic other than a provider clinic offers ambulatory services other than rural health clinic services, maximum reimbursement for these ambulatory services shall be at the levels specified in this part for similar services. For purposes of this item, "provider clinic" means a clinic as defined in Code of Federal Regulations, title 42, section 447.371(a); "rural health clinic services" means those services listed in Code of Federal Regulations, title 42, section 440.20(b); "ambulatory services furnished by a rural health clinic" means those services listed in Code of Federal Regulations, title 42, section 440.20(c).

Q. For laboratory and x–ray services performed by a physician, independent laboratory, or outpatient hospital, the payment rate shall be the lowest of the provider's submitted charge, the provider's individual customary charge submitted during the calendar year specified in the legislation governing maximum payment rates, the 50th percentile of the usual and customary fees based on billings submitted by all providers of the service in the calendar year specified in legislation, or maximum Medicare fee schedules for outpatient clinical diagnostic laboratory services.

R. For medical transportation services, the rates shall be as specified in subitems (1) to (4).

(1) Payment for ambulance service must be the lowest of the medical assistance maximum allowable charge, the provider's usual and customary charge, the charge submitted by the provider, or the payment allowed by Medicare for a similar service. If a provider transports two or more persons simultaneously in one vehicle, the payment must be prorated according to the schedule in subitem (2). Payment for ancillary service to a recipient during ambulance service must be based on the type of ancillary service and is not subject to proration.

(2) Payment for special transportation must be the lowest of the actual charge for the service, the provider's usual and customary rate, or the medical assistance maximum allowable charge. If a provider transports two or more persons simultaneously in one vehicle from the same point of origin, the payment must be prorated according to the following schedule:

Number of Riders	Percent of Allowed Base Rate Per Person in Vehicle	Percent of Allowed Mileage Rate
1	100	100
2	80	50
3	70	34
4	60	25
5–9	50	20
10 or more	40	10

(3) The payment rate for bus, taxicab, and other commercial carriers must be the carrier's usual and customary fee for the service but must not exceed the department's maximum allowable payment for special transportation services.

(4) The payment rate for private automobile transportation must be the amount per mile allowed on the most recent federal income tax return for actual miles driven for business purposes.

(5) The payment rate for air ambulance transportation must be consistent with the level of medically necessary services provided during the recipient's transportation and must be the lowest of the medical assistance maximum allowable charge, the provider's usual and customary charge, the charge submitted by the provider, or the payment allowed by Medicare for a similar service. Payment for air ambulance transportation of a recipient not having a life threatening condition requiring air ambulance transportation shall be at the level of medically necessary services which would have been otherwise provided to the recipient at rates specified in subitems (1) to (4).

S. For medical supplies and equipment, the rates shall be the lowest of the provider's submitted charge, the Medicare fee schedule amount for medical supplies and equipment, or the amount determined as appropriate by use of the methodology set forth in this item. If Medicare has not established a reimbursement amount for an item of medical equipment or a medical supply, then the medical assistance payment shall be based upon the 50th percentile of the usual and customary charges submitted to the department for the item or medical supply for the previous calendar year minus 20 percent. For an item of medical equipment or a medical supply for which no information about usual and customary charges exists for a previous calendar year payments shall be based upon the manufacturer's suggested retail price minus 20 percent.

T. For prosthetics and orthotics, the rate shall be the lower of the Medicare fee schedule amount or the provider's submitted charge.

U. For health services for which items A to T do not provide a payment rate, the department may use competitive bidding, negotiate a rate, or establish a payment rate by other means consistent with statutes, federal regulations, and state rules.

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

History: *12 SR 624; L 1987 c 209 s 39; 16 SR 2518*

9505.0446 HOSPICE CARE PAYMENT RATES AND PROCEDURES.

Subpart 1. **Rate categories.** Providers of hospice care as described in part 9505.0297 are paid at one of four fixed daily rates that apply to each of the four categories of services in subpart 3. The fixed daily rates apply to all services, except for certain physician services as described in subpart 5, and room and board in a long–term care facility as described in subparts 6 and 7.

Subp. 2. **Long–term care facility as residence.** For purposes of this part, a recipient who resides in a long–term care facility is considered to live at home.

Subp. 3. **Categories of service.** Except as otherwise provided by subparts 4 to 6, no payments shall be made for specific services provided by the hospice. Fixed daily rates are calculated under subpart 4 for each of the following categories of services:

A. Routine home care day, which is a day on which a recipient who has elected to receive hospice care is at home and is not receiving continuous care as defined in item B.

B. Continuous home care day, which is a day on which a recipient who has elected to receive hospice care has not been admitted to a facility that provides inpatient care, except when a long–term care facility is the recipient's residence under subpart 2, and the recipient receives hospice care consisting of nursing services, including home health aide or homemaker services, on a continuous basis at home, as provided by part 9505.0297, subpart 17. No fewer than eight hours a day of nursing care must be provided by a registered nurse or licensed practical nurse. Continuous home care may be furnished only during periods of crisis as described in part 9505.0297, subpart 17, and only as necessary to maintain the terminally ill recipient at home.

C. Inpatient respite care day, which is a day on which the recipient who has elected hospice care receives inpatient care in an inpatient facility certified for medical assistance on a short–term basis for respite. This item is subject to the limits provided by part 9505.0297, subpart 18. This item does not apply to a recipient whose residence is a long–term care facility under subpart 2.

D. General inpatient care day, which is a day on which a recipient who has elected hospice care receives general inpatient care in a hospital or skilled nursing facility that provides inpatient care for control of pain or management of acute or chronic symptoms that cannot be managed in other settings. This item does not apply to a recipient who receives inpatient care in a long–term care facility in which the recipient is a resident under subpart 2.

Subp. 4. **Payments and limitations.** Medical assistance will pay a hospice for each day a recipient is under the hospice's care. Payment is in the same amounts, uses the same methodology, and is subject to the same limits and cap amount used by Medicare under Code of Federal Regulations, title 42, sections 418.301 to 418.309, as amended through October 1, 1987, except that the inpatient day limit on both inpatient respite care days and general inpatient care days does not apply to recipients afflicted with acquired immunodeficiency syndrome (AIDS), as provided by United States Code, title 42, section 1396d(o)(1)(B). The rates are determined by the Health Care Financing Administration (HCFA), United States Department of Health and Human Services, as provided by Code of Federal Regulations, title 42, section 418.306, as amended through October 1, 1987, and as adjusted by HCFA for the Medicare co–pay amounts not allowed under medical assistance. Payments to long–term care facilities under subparts 6 and 7 are not included in the cap amount. Changes in rates are announced in the Federal Register. No payment will be made for bereavement counseling under part 9505.0297, subpart 19.

Subp. 5. **Payment for physician services.** Physician services are paid according to items A to C.

A. The services specified in subitems (1) and (2) are included in the rates provided by subpart 4:

(1) general supervisory services of the hospice's medical director; and

(2) participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the hospice's interdisciplinary group.

B. Other than for services described in item A, medical assistance shall pay the hospice for physician services furnished by physicians who are employees of the hospice or who provide services under arrangements with the hospice, at the rate provided by part 9505.0445, item E. Payment for these physician services is included in the amount subject to the cap amount in subpart 4. No payment will be made to the hospice for services donated by physicians who are employees of the hospice or who provide services under arrangements with the hospice.

C. Services of the recipient's attending physician, if the physician is not an employee of the hospice or is not providing services under arrangements with the hospice, are not considered hospice services and are not included in the amount subject to the cap amount in subpart 4. These services are reimbursed according to parts 9505.0345 and 9505.0445, item E.

Subp. 6. **Payment for room and board in long–term care facilities.** If a recipient resides in a long–term care facility under subpart 2 that is certified as a medical assistance provider and the recipient has elected medical assistance coverage of hospice services, the long–term care facility shall not be paid by medical assistance under parts 9549.0010 to 9549.0080, but shall be paid by the hospice at a rate negotiated by the long–term care facility and the hospice.

Subp. 7. **Payment to hospice for residents of long–term care facilities.** The commissioner shall establish the payments to hospices for the room and board of medical assistance recipients who reside in long–term care facilities certified by medical assistance, as provided by items A and B.

A. The daily room and board payment rate shall be either:

(1) 83 percent of the long–term care facility's daily payment rate for the recipient's resident class, as determined under parts 9549.0010 to 9549.0080; or

(2) 83 percent of the long–term care facility's daily payment rate for the recipient's certification level, if the long–term care facility is not subject to parts 9549.0010 to 9549.0080.

B. The payment to the hospice is the product of the hospice's daily room and board payment rate determined in item A and the number of days for which the recipient resides in the long–term care facility in the month, less the recipient's spend down amount for that month under part 9505.0065, subpart 11, item F.

Statutory Authority: *MS s 256B.02 subd 8 cl (20)*

History: *13 SR 1861*

9505.0450 BILLING PROCEDURES; GENERAL.

Subpart 1. **Billing for usual and customary fee.** A provider shall bill the department for the provider's usual and customary fee only after the provider has provided the health service to the recipient.

Subp. 2. **Time requirements for claim submission.** Except as in subpart 4, a provider shall submit a claim for payment no later than 12 months after the date of service to the recipient and shall submit a request for an adjustment to a payment no later than six months after the payment date. The department has no obligation to pay a claim or make an adjustment to a payment if the provider does not submit the claim within the required time.

Subp. 3. **Retroactive billing.** If the recipient is retroactively eligible for medical assistance and notifies the provider of the retroactive eligibility, the provider may bill the department the provider's usual and customary charge. If the recipient paid any portion of the provider's usual and customary charge during this period, the provider must reimburse the recipient the actual amount paid by the recipient but not more than the amount paid to the provider by medical assistance. Failure of the provider to comply with this part shall not be appealable by the recipient under Minnesota Statutes, section 256.045.

Subp. 4. **Exceptions to time requirements.** A provider may submit a claim for payment more than 12 months after the date of service to the recipient if one of the circumstances in items A to D exists. The department shall pay the claim if it satisfies the other requirements of a claim for a covered service.

A. The medical assistance claim was preceded by a claim for payment under Medicare which was filed according to Medicare time limits. To be eligible for payment, the claim must be presented to the department within six months of the Medicare determination.

B. Medical assistance payment of the claim is ordered by the court and a copy of the court order accompanies the claim or an appeal under Minnesota Statutes, section 256.045, is upheld. To be eligible for payment, the claim must be presented within six months of the court order.

C. The provider's claim for payment was rejected because the department received erroneous or incomplete information about the recipient's eligibility. To be eligible for payment, the provider must resubmit the claim to the department within six months of the erroneous determination, together with a copy of the original claim, a copy of the corresponding remittance advice, and any written communication the provider has received from the local agency about the claim. The local agency must verify to the department the recipient's eligibility at the time the recipient received the service.

D. The provider's claim for payment was erroneously rejected by the department. To be eligible for payment, the provider must resubmit the claim within six months of receipt of the notice of the erroneous determination by sending the department a copy of the original claim, a copy of the remittance advice, any written communication about the claim sent to the provider by the local agency or department, and documentation that the original claim was submitted within the 12–month limit in subpart 2.

Subp. 5. **Format of claims.** To be eligible for payment, a provider must enter on the claim the diagnosis and procedure codes required by the department and submit the claim on forms or in the format specified by the department. The provider must include with the claim information about a required prior authorization or second surgical opinion. Further, the provider shall submit with the claim additional records or reports requested by the department as necessary to determine compliance with parts 9505.0170 to 9505.0475.

Subp. 6. **Repeated submission of nonprocessible claims.** A provider's repeated submission of claims that cannot be processed without obtaining additional information shall constitute abuse and shall be subject to the sanctions available under parts 9505.2160 to 9505.2245.

Subp. 7. **Direct billing by provider.** Except as in parts 9505.0070 and 9505.0440, a provider or the provider's business agent as in part 9505.0455 shall directly bill the department for a health service to a recipient.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0455 BILLING PROCEDURE; BUSINESS AGENT.

A health service rendered by a provider may be billed by the provider's business agent, if the business agent's compensation is related to the actual cost of processing the billing; is not related on a percentage or other basis to the amount that is billed; and is not dependent upon collection of the payment.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0460 CONSEQUENCES OF A FALSE CLAIM.

A provider who wrongfully obtains a medical assistance payment is subject to Minnesota Statutes, sections 256B.064, 256B.121, 609.466, and 609.52; section 1909 of the Social Security Act; and parts 9505.2160 to 9505.2245.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0465 RECOVERY OF PAYMENT TO PROVIDER.

Subpart 1. **Department obligations to recover payment.** The department shall recover medical assistance funds paid to a provider if the department determines that the payment was obtained fraudulently or erroneously. Monetary recovery under the medical assistance program is permitted for the following:

A. intentional and unintentional error on the part of the provider or state or local welfare agency;

B. failure of the provider to comply fully with all authorization control requirements, prior authorization procedures, or billing procedures;

C. failure to properly report third–party payments; and

D. fraudulent or abusive actions on the part of the provider.

Subp. 2. **Methods of monetary recovery.** The monetary recovery may be made by withholding current payments due the provider, by demanding that the provider refund amounts so received as provided in part 9505.1950, or by any other legally authorized means.

Subp. 3. **Interest charges on monetary recovery.** If the department allows the provider to repay medical assistance funds by installment payments, the provider must pay interest on the funds to be recovered. The interest rate shall be the rate established by the Department of Revenue under Minnesota Statutes, section 270.75.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0470 PROVIDER RESPONSIBILITY FOR BILLING PROCEDURE.

For the purposes of parts 9505.0170 to 9505.0475 and 9505.1760 to 9505.2150, a provider is responsible for all medical assistance payment claims submitted to the department for health services furnished by the provider or the provider's designee to a recipient regardless of whether the claim is submitted by the provider or the provider's employee, vendor, or business agent, or an entity who has a contract with the provider.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0475 SUSPENSION OF PROVIDER CONVICTED OF CRIME RELATED TO MEDICARE OR MEDICAID.

Subpart 1. **Crime related to Medicare.** A provider convicted of a crime related to the provision, management, or administration of health services under Medicare is suspended from participation under the medical assistance program. The effective date of the suspension is the date established by the Department of Health and Human Services; the period of suspension is the period established by the Department of Health and Human Services.

Subp. 2. **Crime related to medical assistance.** A provider convicted of a crime related to the provision, management, or administration of health services under medical assistance is suspended from participation under the medical assistance program. The effective date of suspension is the date of conviction. The period of suspension is the period of any sentence imposed by the sentencing court, even if the sentence is suspended or the provider is placed on probation. A provider is provisionally suspended upon conviction and pending sentencing.

Subp. 3. **Definition of "convicted."** "Convicted" for purposes of this part means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from the judgment is pending, and includes a plea of guilty or nolo contendere.

Subp. 4. **Suspension after conviction of person with ownership interest.** This part also applies to and results in the suspension of any provider when a person who has an ownership or control interest in the provider, as defined and determined by Code of Federal Regulations, title 42, sections 455.101 and 455.102, is convicted of a crime related to medical assistance. A provider suspended under this subpart may seek reinstatement at the time the convicted person ceases to have any ownership or control interest in the provider.

Subp. 5. **Notice of suspension.** The commissioner shall notify a provider in writing of suspension under this part. The notice shall state the reasons for the suspension, the effective date and duration of the suspension, and the provider's right to appeal the suspension.

Subp. 6. **Right to appeal.** A provider suspended under this part may file an appeal pursuant to Minnesota Statutes, section 256B.064, and part 9505.2150. The appeal shall be heard by an administrative law judge according to Minnesota Statutes, sections 14.48 to 14.56. Unless otherwise decided by the commissioner, the suspension remains in effect pending the appeal.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0476 [Repealed, 17 SR 1448; 17 SR 1454]

9505.0477 [Repealed, 17 SR 1448; 17 SR 1454]

9505.0478 [Repealed, 17 SR 1448; 17 SR 1454]

9505.0479 [Repealed, 17 SR 1448; 17 SR 1454]

9505.0480 [Repealed, 17 SR 1448; 17 SR 1454]

9505.0481 [Repealed, 17 SR 1448; 17 SR 1454]

9505.0482 [Repealed, 17 SR 1448; 17 SR 1454]

9505.0483 [Repealed, 17 SR 1448; 17 SR 1454]

9505.0484 [Repealed, 17 SR 1448; 17 SR 1454]

9505.0485 [Repealed, 17 SR 1448; 17 SR 1454]

9505.0486 [Repealed, 17 SR 1448; 17 SR 1454]

9505.0487 [Repealed, 17 SR 1448; 17 SR 1454]

9505.0488 [Repealed, 17 SR 1448; 17 SR 1454]

9505.0489 [Repealed, 17 SR 1448; 17 SR 1454]

9505.0490 [Repealed, 17 SR 1448; 17 SR 1454]

CASE MANAGEMENT SERVICES FOR PERSONS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS

9505.0491 MEDICAL ASSISTANCE PAYMENT FOR CASE MANAGEMENT SERVICES.

Subpart 1. [Repealed, 17 SR 1448; 17 SR 1454]

Subp. 2. [Repealed, 17 SR 1448; 17 SR 1454]

Subp. 3. [Repealed, 17 SR 1448; 17 SR 1454]

Subp. 4. [Repealed, 17 SR 1448; 17 SR 1454]

Subp. 5. [Repealed, 17 SR 1448; 17 SR 1454]

Subp. 6. [Repealed, 17 SR 1448; 17 SR 1454]

Subp. 7. **Statewide payment amount for case management services.** For the calendar year beginning January 1, 1989, the commissioner shall determine the statewide medical assistance hourly payment amount for case management service provided to a recipient as specified in items A to C. The amount of the payment is the result obtained in item C.

A. Determine the highest hourly salary of a social worker at the seventh step of the entry level approved by a Minnesota County Board of Commissioners by August 2, 1988, for a person employed as an entry level social worker for calendar year 1988.

B. Multiply the amount in item A by 1.40 as an allowance for fringe benefits and administrative overhead.

C. Divide the amount calculated in item B by 0.7 as an allowance for the time a case manager spends in work–related activities that are not eligible for reimbursement under parts 9505.0476 to 9505.0491.

Subp. 8. **Statewide payment amount for case management services; adjustment in state fiscal years after state fiscal year 1991.** Unless the legislature acts otherwise, the

commissioner shall adjust the statewide medical assistance hourly payment amount for case management services to be consistent with revisions enacted after 1990 in legislation governing maximum medical assistance payment rates beginning with state fiscal year 1992.

Subp. 9. [Repealed, 17 SR 1448; 17 SR 1454]

Subp. 10. [Repealed, 17 SR 1448; 17 SR 1454]

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

History: *13 SR 1439; 17 SR 1448; 17 SR 1454*

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 all or part of a recipient's inpatient hospital services are 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 9500.1070, subparts 1, 4, 6, 12 to 15, and 23; 9500.1090 to 9500.1155; 9505.0170 to 9505.0475; 9505.1000 to 9505.1040; and 9505.5000 to 9505.5105.

Subp. 3a. **Admitting diagnosis.** "Admitting diagnosis" means the physician's tentative or provisional diagnosis of the recipient's condition as a basis for examination and treatment when the physician requests admission certification.

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. 4a. **Authorization number.** "Authorization number" means the number issued by the medical review agent that establishes that the surgical procedure requiring a second surgical opinion is medically appropriate.

Subp. 5. **Certification number.** "Certification number" means the number issued by the medical review agent that establishes that all or part of a recipient's inpatient hospital services are medically necessary.

Subp. 6. **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 inpatient hospital services to the recipient.

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

Subp. 10a. **Diagnostic category.** "Diagnostic category" means the list of diagnosis–related groups in the diagnostic classification system established under Minnesota Statutes, section 256.969, subdivision 2, and defined in part 9500.1100, subpart 20a.

Subp. 10b. **Diagnostic category validation or validate the diagnostic category.** "Diagnostic category validation" or "validate the diagnostic category" refers to the process

of comparing the medical record to the information submitted on the inpatient hospital billing form required by the department to ascertain the accuracy of the information upon which the diagnostic category was assigned.

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 by or under the supervision of a physician after a recipient's admission to a hospital and furnished in the hospital for the care and treatment of the recipient. The inpatient hospital service may be furnished by a hospital, physician, or a vendor of an ancillary service which is prescribed by a physician and which is eligible for medical assistance or general assistance medical care reimbursement.

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. For purposes of parts 9505.0500 to 9505.0540, "medical assistance" includes general assistance medical care unless otherwise specified.

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, retrospective reviews, and second surgical opinions if such opinions are a term of the agent's contract with the department.

Subp. 19. **Medically necessary.** "Medically necessary" means an inpatient hospital service that is consistent with the recipient's diagnosis or condition, and under the criteria in part 9505.0540 cannot be provided on an outpatient basis.

Subp. 19a. **Medically appropriate or medical appropriateness.** "Medically appropriate" or "medical appropriateness" refers to a determination, by a medical review agent or the department, that the recipient's need for a surgical procedure requiring a second surgical opinion meets the criteria in part 9505.0540 or that a third surgical opinion has substantiated the need for the procedure.

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 admitting or principal diagnosis or a specialty area related to the admitting or principal 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. 23a. **Principal diagnosis.** "Principal diagnosis" means the condition established, after study, to be chiefly responsible for causing the admission of the recipient to the hospital for inpatient hospital services.

Subp. 23b. **Principal procedure.** "Principal procedure" means a procedure performed for definitive treatment of the recipient's principal diagnosis rather than one performed for

diagnostic or exploratory purposes or a procedure necessary to take care of a complication. When multiple procedures are performed for definitive treatment, the principal procedure is the procedure most closely related to the principal diagnosis.

Subp. 23c. **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. Providers include hospitals, admitting physicians, and vendors of other services.

Subp. 24. **Readmission.** "Readmission" means an admission that occurs within 15 days of a discharge of the same recipient. The 15–day period does not include the day of discharge or the day of readmission.

Subp. 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 validating the diagnostic category and determining the medical necessity of the admission, the medical necessity of any inpatient hospital services provided, the medical appropriateness of a surgical procedure requiring a second opinion, and whether all medically necessary inpatient hospital services were provided.

Subp. 28. **Second surgical opinion.** "Second surgical opinion" means the confirmation or denial of the medical appropriateness of a proposed surgery as specified in parts 9505.5000 to 9505.5105.

Subp. 29. **Transfer.** "Transfer" means the movement of a recipient after admission from one hospital directly to another.

Statutory Authority: *MS s 256B.04 subds 2,15; 256B.503; 256D.03 subd 7 para (b)*

History: *9 SR 2296; 11 SR 1687; 13 SR 1688; 18 SR 1115*

9505.0510 SCOPE.

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 under parts 9500.1090 to 9500.1155 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 9505.5030 and second surgical opinions established under parts 9505.5035 to 9505.5105. A hospital or admitting physician who seeks medical assistance or general assistance medical care payment for inpatient hospital services provided to a Minnesota recipient must comply with the requirements of parts 9505.0500 to 9505.0540 unless the hospital or admitting physician has received prior authorization for inpatient hospital services under parts 9505.0170 to 9505.0475. Admission certification must be obtained when a recipient moves from one hospital with a provider number to another hospital with a different provider number or from one unit within a hospital to another unit with a different provider number in the same hospital. For purposes of this part, "provider number" means a number issued by the department to a provider who has signed a provider agreement under part 9505.0195.

Statutory Authority: *MS s 256B.04 subds 2,15; 256B.503; 256D.03 subd 7 para (b)*

History: *9 SR 2296; 11 SR 1687; 13 SR 1688*

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 admis-

sion 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 to C shall be excluded from the requirement in subpart 1.

A. Admission certification is not required before an emergency admission and shall be subject to subpart 4, item B.

B. Admission certification is not required for delivery of a newborn or a stillbirth, inpatient dental procedures, or inpatient hospital services for which a recipient has been approved under Medicare. However, if an inpatient hospital service is also covered under Medicare, then denial of the service under Medicare on grounds other than medical necessity shall also constitute sufficient grounds for denying admission certification for the service under medical assistance. The admission of a pregnant woman that does not result in the delivery of a newborn or a stillbirth within 24 hours of her admission shall be subject to retroactive admission certification.

C. Admission of a recipient who has been approved by the county for inpatient hospital services for chemical dependency as specified in parts 9530.6600 to 9530.6655 may occur without admission certification, provided that the inpatient hospital chemical dependency services to the recipient during the recipient's stay in the hospital are not to be billed to medical assistance under parts 9500.1090 to 9500.1155.

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

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 (9):

(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 or a transfer;

(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 or the procedure requiring a second surgical opinion is medically appropriate; or

(9) when applicable, information needed to prove that a procedure requiring a second surgical opinion meets the criteria for exemption from the requirement.

C. Provide the following information when applicable:

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

(2) expected date of surgery;

(3) affirmation that prior authorization has been received;

(4) affirmation that a procedure requiring a second surgical opinion that was denied by the medical review agent has been approved by a third physician; and

(5) when requested by the medical review agent, documentation that the procedure requiring a second surgical opinion meets the criteria for exemption from the requirement.

D. Inform the hospital of the certification number.

E. Provide the hospital documentation necessary for the verification required in subpart 4, item D.

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

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

A. Obtain the certification number and the authorization number, if required under parts 9505.5000 to 9505.5105, from the admitting physician.

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

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

(2) A surgical procedure requiring a second surgical opinion that meets the requirements of part 9505.5040, item B or C, for exemption from the second opinion.

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

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

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

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

D. Within 20 days, exclusive of weekends and holidays, of the date of a written request by the medical review agent, obtain and submit to the medical review agent an admitting physician's verification that a procedure requiring a second surgical opinion has been approved by a third physician. The verification must include at least the signed form required by the department to approve a procedure requiring a second surgical opinion.

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, whether a surgical procedure requires a second surgical opinion or is exempt from the requirement, and whether a procedure requiring a second surgical opinion meets the criteria of appropriateness established in part 9505.0540 or requires the approval of a third physician;

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 by certified letter of the admission certification determination to the admitting physician and the hospital, and a written notice to the recipient within five days of the determination, exclusive of weekends and holidays;

E. determine if admission of a retroactively eligible recipient was medically necessary and if the surgical procedure requiring a second opinion was medically appropriate;

F. conduct a concurrent, continued stay, or retrospective review of a recipient's medical record as specified in subpart 10;

G. provide for a reconsideration of a denial or withdrawal of admission certification, and of an authorization number denied or withdrawn under subpart 8, item C;

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

I. 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;

J. mail a written notice by certified letter 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;

K. provide for consideration of a request for retroactive admission certification;

L. validate the diagnostic category; and

M. perform other duties as specified in the contract between the medical review agent and the department.

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 or authorization of surgical procedure requiring a second surgical opinion.** The procedure for admission certification or authorization of a surgical procedure requiring a second surgical opinion 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 or whether a procedure requiring a second surgical opinion is appropriate or meets the criteria for exemption from the requirement.

B. If the clinical evaluator determines that one of the conditions in item A exists, the medical review agent shall issue a certification or authorization number.

C. If the clinical evaluator determines that a procedure requiring a second surgical opinion does not meet the criteria for exemption under part 9505.5040, except items B, C, and F, the medical review agent shall notify the admitting physician by phone and mail the admitting physician and the recipient a written notice within 20 days of the determination. If the exemption is denied, the recipient who wants the surgery may obtain a second or third surgical opinion. Exemptions from the second surgical opinion under part 9505.5040, items B and C, shall be subject to subpart 4, item B. Exemptions from the second surgical opinion under part 9505.5040, item F, shall be subject to part 9505.5096, subpart 4. If the medical review agent determines that the procedure requiring a second surgical opinion was not entitled to an exemption or that the surgical procedure was not medically appropriate under part 9505.5040, items B, C, and F, the medical review agent shall not issue or shall withdraw the authorization number and notify the admitting physician and the hospital of denial of the authorization number.The notice shall be in writing, mailed by certified letter within 20 days of the determination, and shall state that the admitting physician or the hospital may request reconsideration of the denial under subpart 9 or may directly appeal the denial under Minnesota Statutes, chapter 14.

D. If the clinical evaluator is unable to determine that the admission is medically necessary or that a procedure requiring a second surgical opinion is appropriate, the evaluator shall contact a physician adviser.

E. If the physician adviser determines that the admission is medically necessary or that a procedure requiring a second surgical opinion is appropriate, the medical review agent shall issue a certification or authorization number.

F. If the physician adviser is unable to determine that the admission is medically necessary or that a procedure requiring a second surgical opinion is appropriate, 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, except in the case of a procedure requiring a second surgical opinion. In this case, the medical review agent shall notify the admitting physician that the recipient may obtain the opinion of a third physician as provided in parts 9505.5050 to 9505.5105.

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

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

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

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

Subp. 9. **Reconsideration.** The admitting physician or the hospital may request reconsideration of a decision to deny or withdraw an admission certification or an authorization number under subpart 8, item C. The admitting physician or the hospital shall submit the request in writing to the medical review agent together with the recipient's medical record and any additional information within 30 days of the date of receipt of the certified letter denying or withdrawing admission certification or the authorization number. Upon receipt of the request, the medical record, and any additional information, the medical review agent shall appoint at least three physician advisers, none of whom shall have been involved previously in the procedure for the recipient's admission certification or authorization number, to hear the reconsideration. The reconsideration may be conducted by means of a telephone conference call. The physician advisers may seek additional facts and medical advice as necessary to decide whether the admission is medically necessary or whether the surgical procedure requiring a second surgical opinion meets the criteria of exemption or is medically appropriate under part 9505.5040, items B, C, and F. The reconsideration shall be completed within 45 days of the receipt of the information necessary to complete the reconsideration. The outcome of the reconsideration shall be the one chosen by the majority of the physician advisers appointed to consider the request. The admitting physician or the hospital may appeal the determination of the physician advisers according to the contested case provisions of Minnesota Statutes, chapter 14, by filing a written notice of appeal with the commissioner within 30 days of the date of receipt of the certified letter upholding the denial or withdrawal of admission certification or authorization number.However, an admitting physician or hospital that does not request reconsideration or appeal under the contested case procedures of Minnesota

Statutes, chapter 14, within 30 days after the denial or withdrawal of admission certification or authorization number is not entitled to an appeal under Minnesota Statutes, chapter 14.

Subp. 9a. **Retention or withdrawal of certification number.** When a hospital discharges a recipient who is subsequently readmitted to the same or a different hospital or transfers a recipient to another hospital, the readmission or transfer is subject to the procedures in part 9505.0540, subparts 3 to 6. The hospital or admitting physician who disagrees with the medical review agent's determination under this subpart may request reconsideration as specified in subpart 9.

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

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 certified letter mailed within five days, exclusive of weekends and holidays, of the determination. The notice shall state the right of the admitting physician and hospital to request a reconsideration or appeal under subpart 9.

E. If the diagnostic category validation shows that the diagnostic category was inaccurately assigned, the department shall adjust the reimbursement as applicable to the diagnostic category that is accurate for the recipient's condition.

F. If the medical review agent conducting a retrospective review finds the recipient's medical record is inadequate to justify that a surgical procedure requiring a second opinion is medically appropriate, or that an exemption under part 9505.5040 was appropriate, the medical review agent may request a hospital to submit, at the hospital's expense, documentation substantiating the opinion of the third physician that the surgical procedure was medically appropriate, or that the exemption under part 9505.5040 was appropriate. The hospital shall submit the documentation within 20 days, exclusive of weekends and holidays, of the date of the notice requesting the documentation.

G. If the clinical evaluator is unable to determine from the documentation in the recipient's medical records the reasons for the recipient's discharge and readmission, the clinical evaluator shall submit the medical records of the recipient's discharge and readmission to a physician adviser. The physician adviser shall review the records and determine the nature of the discharge and readmission according to the criteria in part 9505.0540, subparts 3 to 5, and if the determination of the medical review agent is different from that of the admitting physician or hospital, then the medical review agent shall notify the admitting physician

or hospital by certified letter mailed within five days, exclusive of weekends and holidays, of the determination. The notice shall state the right of the admitting physician and hospital to request a reconsideration under subpart 9.

Subp. 11. **Consequences of withdrawal of admission certification or authorization number; general.** The department or the medical review agent shall withdraw the certification number or authorization number and may take action as specified in items A to F if the medical review agent determines any of the following: (1) that the admission was not medically necessary; (2) that all medically necessary inpatient hospital services were not provided; (3) that some or all of the inpatient hospital services were not medically necessary; (4) that within 20 days, exclusive of weekends and holidays, the hospital has failed to comply with the department's or the medical review agent's request to submit the medical record or other required information to support that the admission was medically necessary, that all medically necessary inpatient hospital services were provided, or that some or all of the inpatient hospital services provided were medically necessary; or, that the information submitted by the hospital was inadequate to support that the admission was medically necessary, that all medically necessary inpatient hospital services were provided, or that some or all of the inpatient hospital services provided were medically necessary; (5) that documentation submitted by the hospital at the request of the department or the medical review agent does not support that the surgical procedure was medically appropriate, or that the exemption under part 9505.5040 was appropriate; or (6) that within 20 days, exclusive of weekends and holidays, the hospital has failed to comply with the medical review agent's request to submit documentation to substantiate the opinion of a third physician that the surgical procedure was medically appropriate, or that the exemption under part 9505.5040 was appropriate.

A. For hospitals receiving payments under parts 9500.1090 to 9500.1155, if the admission was not medically necessary or the medical record does not adequately document that the admission was medically necessary, the entire payment shall be denied or recovered as provided in subpart 15. 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 9505.2160 to 9505.2245.

B. For hospitals receiving payments under parts 9500.1090 to 9500.1155, if the admission was medically necessary but some or all of the additional inpatient hospital services were not or will not be medically necessary, or the medical record does not adequately document that the additional inpatient hospital services were necessary, payment for the additional services shall be denied or recovered as provided in subpart 15. 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 9505.2160 to 9505.2245.

C. If the admission was not medically necessary or the medical record does not adequately document that the admission was medically necessary, payment shall be denied or recovered from the admitting physician and other vendors of inpatient hospital services as provided in subpart 15. If the admitting physician and other vendors failed to provide services that were medically necessary, the matter shall be referred to the department which may take action under parts 9505.2160 to 9505.2245.

D. If additional inpatient hospital services were not or will not be medically necessary, or the medical record did not adequately document that the additional inpatient hospital services were medically necessary, payment for the additional services shall be denied or recovered from the admitting physician and other vendors of inpatient hospital services as provided in subpart 15. 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 9505.2160 to 9505.2245. If the admitting physician and vendors failed to provide services that were medically necessary, the matter shall be referred to the department which may take action under parts 9505.2160 to 9505.2245.

E. If within 20 days, exclusive of weekends and holidays, the hospital failed to comply with the department's or the medical review agent's request to submit the medical record or other required information to support (1) that the admission was medically necessary; (2) that all medically necessary inpatient hospital services were provided; or (3) that some or all of the inpatient hospital services provided were medically necessary; or, if the

information submitted by the hospital was inadequate to support clauses (1) to (3) of this item, all or part of the payment shall be denied or recovered as provided in items A to D.

F. If the documentation does not support that the surgical procedure was medically appropriate or that the exemption under part 9505.5040 was appropriate, or if the hospital failed to comply with the medical review agent's request to submit documentation to substantiate the opinion of the third physician that the surgical procedure was medically appropriate or that the exemption under part 9505.5040 was appropriate, payment for the surgical procedure shall be denied or recovered from the hospital, admitting physician, or other vendors as provided in subpart 15.

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

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

Recovery of overpayments may be made by:

A. adjusting the provider's invoice to the difference between the billed amount and the correct amount;

B. canceling the incorrect invoice and directing the provider to submit a correct invoice;

C. withholding or offsetting the payment due the provider for other medical assistance or general assistance medical care services; or

D. using any other remedy available under state or federal law or rules.

Statutory Authority: *MS s 256B.04 subds 2,15; 256B.503; 256D.03 subd 7 para (b)*

History: *9 SR 2296; 11 SR 1687; 13 SR 1688*

9505.0521 PROHIBITION OF RECOVERY FROM RECIPIENT.

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

Statutory Authority: *MS s 256B.04 subds 2,15; 256B.503; 256D.03 subd 7 para (b)*

History: *13 SR 1688*

9505.0522 RECIPIENT'S RIGHT TO APPEAL.

A recipient who is denied inpatient hospital services because of the medical review agent's determination that the services are not medically necessary or who is denied a surgical procedure requiring a second surgical opinion because of the medical review agent's determination that the surgical procedure is not appropriate, may appeal the medical review agent's determination under Minnesota Statutes, section 256.045.

Statutory Authority: *MS s 256B.04 subds 2,15; 256B.503; 256D.03 subd 7 para (b)*

History: *13 SR 1688*

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, 20 Maguire Road, Lexington, Massachusetts, 02173, 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, 25 Constitution Avenue, Saint Paul, Minnesota 55155. The criteria are not subject to frequent change.

Statutory Authority: *MS s 256B.04 subds 2,15; 256B.503; 256D.03 subd 7 para (b)*

History: *9 SR 2296; 11 SR 1687; 13 SR 1688*

9505.0540 CRITERIA TO DETERMINE MEDICAL NECESSITY OR APPROPRIATENESS.

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

In determining whether a surgical procedure requiring a second surgical opinion is medically appropriate, the medical review agent shall follow the criteria published in the State Register pursuant to Minnesota Statutes, section 256B.0625, subdivision 24.

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.

Subp. 3. **Readmission considered as a second admission.** The medical review agent shall issue a certification number for a readmission that meets the criteria for medical necessity specified in subpart 1 whether the admitting and readmitting hospitals are the same or different. The medical record of the admission must state why the recipient was discharged from the hospital and what the recipient's medical status was upon discharge, and the medical record of the readmission must state why the recipient is being readmitted and what the recipient's medical status is at readmission. Both the admission and the readmission shall be subject to a retrospective review as provided in part 9505.0520, subpart 10. If the reason for

the discharge and the reason for the readmission meet one set of circumstances specified in items A to D, the medical review agent shall determine that both the admission and the readmission shall retain the certification number subject to the hospitals' and admitting physicians' compliance with all requirements of parts 9505.0500 to 9505.0540.

A. The readmission results from the recipient leaving the hospital against medical advice.

B. The readmission results from the recipient being noncompliant with medical advice that is recorded on the recipient's medical record as being given to the recipient at the admitting hospital. For purposes of this part, "recipient being noncompliant with medical advice" means that the recipient, fully informed of his or her medical condition, and fully understanding the need for the treatment and the follow–up discharge instructions, if any, refuses to adhere to the treatment or to follow the discharge instructions.

C. The readmission results from a new episode of the same diagnosis of an episodic illness or condition.

D. The readmission results from the fact that the recipient's discharge from the admitting hospital and readmission are medically necessary according to prevailing medical standards, practice, and usage.

Subp. 4. **Readmission considered as continuous with admission.** The medical review agent shall determine that a readmission of a recipient is continuous with the recipient's admission whether the admitting and readmitting hospitals are the same or different if the circumstances requiring the recipient's readmission meet one set of the circumstances specified in items A to C. The medical review agent shall issue a certification number if the readmission meets the criteria for medical necessity specified in subpart 1. The medical record of the admission must state why the recipient was discharged from the hospital and what the recipient's medical status was upon discharge, and the medical record of the readmission must state why the recipient is being readmitted and what the recipient's medical status is at readmission. Both the admission and the readmission shall be subject to a retrospective review as provided in part 9505.0520, subpart 10. Upon completing the retrospective review and determining whether the readmission and admission are consistent with item A, B, or C, the medical review agent shall take the action specified in the item that applies. Medical assistance payment for the inpatient hospital services retaining the certification number after the determination resulting from the retrospective review shall be paid according to parts 9500.1090 to 9500.1155 for the diagnostic category assigned to the recipient's principal diagnosis of the admission and readmission. In each circumstance, retention of the certification number shall be subject to the hospital's and admitting physician's compliance with all requirements of parts 9505.0500 to 9505.0540.

A. The recipient was discharged from the admitting hospital without receiving the procedure or treatment of the condition diagnosed during the admission because of the hospital's or physician's preference or because of a scheduling conflict. If the admitting and readmitting hospitals are the same, the medical review agent shall withdraw the certification number of the readmission and determine the admission eligible to retain the certification number. If the admitting and readmitting hospitals are not the same, the medical review agent shall apply the requirements under subpart 5, item C, regarding readmission eligible for a transfer payment.

B. The recipient's discharge was not appropriate according to prevailing medical standards, practice, and usage. If the admitting and readmitting hospitals are the same, the medical review agent shall determine the admission eligible to retain the certification number and withdraw the certification number of the readmission. If the admitting and readmitting hospitals are different, the medical review agent shall withdraw the certification number of the admission and shall determine the readmission eligible to retain a certification number.

C. The recipient's discharge and readmission to the same hospital results from the preference of the recipient or the recipient's family that the recipient's treatment be delayed, that the recipient be discharged without receiving the necessary procedure or treatment, and that the recipient be readmitted for the necessary procedure or treatment. If the admitting and readmitting hospitals are the same, the medical review agent shall determine the admission eligible to retain the certification number and withdraw the certification number of the readmission. If the admitting and readmitting hospitals are not the same, the medical review

agent shall apply the requirements under subpart 5, item A, regarding readmission eligible for a transfer payment. For purposes of this part, "preference of the recipient or the recipient's family" means that the recipient or the recipient's family makes a choice to delay or change the location of inpatient hospital services, and the choice is compatible with prevailing medical standards, practices, and usage.

Subp. 5. **Readmission eligible for transfer payment.** The medical review agent shall issue a certification number for a readmission that is eligible for a transfer payment if the readmission meets the criteria for medical necessity specified in subpart 1 and a set of circumstances in item A, B, or C. The medical record of the admission must state why the recipient was discharged from the hospital and what the recipient's medical status was upon discharge, and the medical record of the readmission must state why the recipient is being readmitted and what the recipient's medical status is at readmission. The medical review agent shall conduct a retrospective review of the medical records, determine whether the readmission is consistent with the circumstances in item A, B, or C, and take the action specified in the item. Retention of the certification number by the hospital shall also be subject to the admitting physician's and hospital's compliance with all requirements of parts 9505.0500 to 9505.0540.

A. The readmission results from the preference of the recipient or the recipient's family that the recipient be discharged from the admitting hospital without receiving the necessary procedure or treatment and that the recipient be readmitted to a different hospital to obtain the necessary procedure or treatment. In this case, both hospitals shall retain their certification numbers subject to the hospitals' and admitting physicians' compliance with all requirements of parts 9505.0500 to 9505.0540, and medical assistance payment to each hospital shall be made according to the transfer payment established under part 9500.1128, subpart 2, item D, for the inpatient hospital services necessary for the recipient's diagnosis and treatment.

B. The readmission results from a referral from one hospital to a different hospital because the recipient's medically necessary treatment was outside the scope of the first hospital's available services. In this case, both hospitals shall retain their certification numbers, and medical assistance payment to each hospital shall be made according to the transfer payment established under part 9500.1128, subpart 2, item D, for the inpatient hospital services necessary for the recipient's diagnosis and treatment. If, however, the admission to the first hospital is not due to an emergency and the first hospital knew or had reason to know at the time of admission that the inpatient hospital services that were medically necessary for the recipient's treatment or condition were outside the scope of the hospital's available services and the readmission to another hospital resulted because of the recipient's need for those services, the first hospital's certification number will be withdrawn.

C. The readmission results from a physician's or hospital's scheduling conflict at the admitting hospital. The medical review agent shall determine both hospitals eligible to retain their certification numbers. In this case, medical assistance payment to each hospital shall be made according to the transfer payment established under part 9500.1128, subpart 2, item D, for the inpatient hospital services necessary for the recipient's diagnosis and treatment.

Subp. 6. **Physician adviser's review of readmission.** If the clinical evaluator is unable to determine from the documentation in the recipient's medical records the reasons for the recipient's discharge and readmission, the records shall be reviewed by the physician adviser, according to the procedure in part 9505.0520, subpart 10, item G.

Statutory Authority: *MS s 256B.04 subds 2,15; 256B.503; 256D.03 subd 7 para (b)*

History: *9 SR 2296; 11 SR 1687; 13 SR 1688; 18 SR 1115*

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 children with mental retardation or related conditions, epilepsy, or emotional handicaps, 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 the person or a spouse from private health care coverage or the Minnesota no–fault auto insurance law to the costs of medical care for the person, 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*

History: *12 SR 1148; 17 SR 1279*

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 the 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 the recipient may select the medical providers which are to provide the necessary medical services and goods or if the local agency is reserving the right to designate the medical providers.

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*

History: *17 SR 1279*

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 an attorney, guardian, or personally designated representative, made application for benefits from the CHEP program with the 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 that person's 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 cover-

age 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 a 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 that person and any dependents in any 12 consecutive months exceeding:

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

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

B. qualified nursing home expenses for that person and any dependents in any 12 consecutive months exceeding 20 percent of 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 physician 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 the person's 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 the 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 a 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 or related conditions).

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 the applicant's 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 practicing and acting within the scope of that 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.16. 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 a physician's 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 a 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 a 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 that person's 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; 12 SR 1148; L 1987 c 384 art 2 s 1; 17 SR 1279*

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 a 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 the 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 decedent. 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; 17 SR 1279*

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 entitled, justification of the selection shall be recorded in the case record.

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

History: *17 SR 1279*

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 the applicant's 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*

History: *17 SR 1279*

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 assign-

ments 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 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 the 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*

History: *17 SR 1279*

9505.1230 INCOME CONSIDERED IN SPECIAL CASES.

If a surviving spouse 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*

History: *17 SR 1279*

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 the 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; 17 SR 1279*

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 the resident's behalf to a spouse or guardian.

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

History: *17 SR 1279*

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 the applicant 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, the provider shall not try to collect charges from the patient or the 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; 17 SR 1279*

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 pre-

scribed 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*

9505.1500 [Repealed, 13 SR 1150]

9505.1510 [Repealed, 13 SR 1150]

9505.1520 [Repealed, 13 SR 1150]

9505.1530 [Repealed, 13 SR 1150]

9505.1540 [Repealed, 13 SR 1150]

9505.1550 [Repealed, 13 SR 1150]

9505.1560 [Repealed, 13 SR 1150]

9505.1570 [Repealed, 13 SR 1150]

9505.1580 [Repealed, 13 SR 1150]

9505.1590 [Repealed, 13 SR 1150]

9505.1600 [Repealed, 13 SR 1150]

9505.1610 [Repealed, 13 SR 1150]

9505.1620 [Repealed, 13 SR 1150]

9505.1630 [Repealed, 13 SR 1150]

9505.1640 [Repealed, 13 SR 1150]

9505.1650 [Repealed, 13 SR 1150]

9505.1660 [Repealed, 13 SR 1150]

9505.1670 [Repealed, 13 SR 1150]

9505.1680 [Repealed, 13 SR 1150]

9505.1690 [Repealed, 13 SR 1150]

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

9505.1693 SCOPE AND PURPOSE.

Parts 9505.1693 to 9505.1748 govern the early and periodic screening, diagnosis, and treatment (EPSDT) program.

Parts 9505.1693 to 9505.1748 must be read in conjunction with section 1905(a)(4)(B) of the Social Security Act, as amended through December 31, 1981, and the Code of Federal Regulations, title 42, part 441, subpart B, as amended through October 1, 1987, and section 6403 of the Omnibus Budget Reconciliation Act of 1989. The purpose of the EPSDT program is to identify potentially handicapping conditions in children eligible for medical assistance, to provide diagnosis and treatment for conditions identified, and to encourage parents and their children to use health care services when necessary.

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

History: *13 SR 1150; 16 SR 2518*

9505.1696 DEFINITIONS.

Subpart 1. **Applicability.** As used in parts 9505.1693 to 9505.1748, the following terms have the meanings given them.

Subp. 2. **Child.** "Child" means a person who is eligible for early and periodic screening, diagnosis, and treatment under part 9505.1699.

Subp. 3. **Community health clinic.** "Community health clinic" means a clinic that provides services by or under the supervision of a physician and that:

A. is incorporated as a nonprofit corporation under Minnesota Statutes, chapter 317A;

B. is exempt from federal income tax under Internal Revenue Code of 1986, section 501(c)(3), as amended through December 31, 1987;

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

D. has written clinic policies describing the services provided by the clinic and concerning (1) the medical management of health problems, including problems that require referral to physicians, (2) emergency health services, and (3) the maintenance and review of health records by the physician.

Subp. 4. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 5. **Diagnosis.** "Diagnosis" means the identification and determination of the nature or cause of a disease or abnormality through the use of a health history; physical, developmental, and psychological examination; and laboratory tests.

Subp. 6. **Early and periodic screening clinic or EPS clinic.** "Early and periodic screening clinic" or "EPS clinic" means an individual or facility that is approved by the Minnesota Department of Health under parts 4615.0900 to 4615.2000.

Subp. 7. **Early and periodic screening, diagnosis, and treatment program or EPSDT program.** "Early and periodic screening, diagnosis, and treatment program" or "EPSDT program" means the program that provides screening, diagnosis, and treatment under parts 9505.1693 to 9505.1748; Code of Federal Regulations, title 42, section 441.55, as amended through October 1, 1986; and Minnesota Statutes, section 256B.02, subdivision 8, paragraph (12).

Subp. 8. **EPSDT clinic.** "EPSDT clinic" means a facility supervised by a physician that provides screening according to parts 9505.1693 to 9505.1748 or an EPS clinic.

Subp. 9. **EPSDT provider agreement.** "EPSDT provider agreement" means the agreement required by part 9505.1703, subpart 2.

Subp. 10. **EPSDT screening form.** "EPSDT screening form" means a form supplied by the department that contains the information required under part 9505.1709.

Subp. 11. **Follow–up.** "Follow–up" means efforts by a local agency to ensure that a screening requested for a child is provided to that child and that diagnosis and treatment indicated as necessary by a screening are also provided to that child.

Subp. 12. **Head Start agency.** "Head Start agency" refers to the child development program administered by the United States Department of Health and Human Services, Office of Administration for Children, Youth and Families.

Subp. 13. **Local agency.** "Local agency" means the county welfare board, multicounty welfare board, or human service agency established in Minnesota Statutes, section 256B.02, subdivision 6, and Minnesota Statutes, chapter 393.

Subp. 14. **Medical assistance.** "Medical assistance" means the program authorized by title XIX of the Social Security Act and Minnesota Statutes, chapters 256 and 256B.

Subp. 15. **Outreach.** "Outreach" means efforts by the department or a local agency to inform eligible persons about early and periodic screening, diagnosis, and treatment or to encourage persons to use the EPSDT program.

Subp. 16. **Parent.** "Parent" refers to the genetic or adoptive parent of a child.

Subp. 17. **Physician.** "Physician" means a person who is licensed to provide health services within the scope of the person's profession under Minnesota Statutes, chapter 147.

Subp. 18. **Prepaid health plan.** "Prepaid health plan" means a health insurer licensed and operating under Minnesota Statutes, chapters 60A, 62A, and 62C, and a health maintenance organization licensed and operating under Minnesota Statutes, chapter 62D to provide health services to recipients of medical assistance entitlements.

Subp. 19. **Public health nursing service.** "Public health nursing service" means the nursing program provided by a board of health under Minnesota Statutes, section 145A.10, subdivision 1.

Subp. 20. **Screening.** "Screening" means the use of quick, simple procedures to separate apparently well children from those who need further examination for possible physical, developmental, or psychological problems.

Subp. 21. **Skilled professional medical personnel and supporting staff.** "Skilled professional medical personnel" and "supporting staff" means persons as defined by Code of Federal Regulations, title 42, section 432.2, as amended through October 1, 1987.

Subp. 22. **Treatment.** "Treatment" means the prevention, correction, or amelioration of a disease or abnormality identified by screening or diagnosis.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150; L 1989 c 304 s 137*

9505.1699 ELIGIBILITY TO BE SCREENED.

A person under age 21 who is eligible for medical assistance is eligible for the EPSDT program.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

9505.1701 CHOICE OF PROVIDER.

Subpart 1. **Choice of screening provider.** Except as provided by subpart 3, a child or parent of a child who requests screening may choose any screening provider who has signed an EPSDT provider agreement and a medical assistance provider agreement.

Subp. 2. **Choice of diagnosis and treatment provider.** Except as provided by subpart 3, a child or parent of a child may choose any diagnosis and treatment provider as provided by part 9505.0190.

Subp. 3. **Exception to subparts 1 and 2.** A child who is enrolled in a prepaid health plan must receive screening, diagnosis, and treatment from that plan.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

9505.1703 ELIGIBILITY TO PROVIDE SCREENING.

Subpart 1. **Providers.** An EPSDT clinic or a community health clinic shall be approved for medical assistance reimbursement for EPSDT services if it complies with the requirements of parts 9505.1693 to 9505.1748. A Head Start agency shall be approved as provided by subpart 2.

Subp. 2. **EPSDT provider agreement.** To be eligible to provide screening and receive reimbursement under the EPSDT program, an individual or facility must sign an EPSDT provider agreement provided by the department and a medical assistance provider agreement under part 9505.0195 or be a prepaid health plan.

Subp. 3. **Terms of EPSDT provider agreement.** The EPSDT provider agreement required by subpart 2 must state that the provider must:

A. screen children according to parts 9505.1693 to 9505.1748;

B. report all findings of the screenings on EPSDT screening forms; and

C. refer children for diagnosis and treatment if a referral is indicated by the screening.

The EPSDT provider agreement also must state that the department will provide training according to part 9505.1712 and will train and consult with the provider on billing and reporting procedures.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

9505.1706 REIMBURSEMENT.

Subpart 1. **Maximum payment rates.** Payment rates shall be as provided by part 9505.0445, item M.

Subp. 2. **Eligibility for reimbursement; Head Start agency.** A Head Start agency may complete all the screening components under part 9505.1718, subparts 2 to 14 or those components that have not been completed by another provider within the six months before completion of the screening components by the Head Start agency. A Head Start agency that completes the previously incomplete screening components must document on the EPSDT screening form that the other screening components of part 9505.1718, subparts 2 to 14, have been completed by another provider.

The department shall reimburse a Head Start agency for those screening components of part 9505.1718, subparts 2 to 14, that the Head Start agency has provided. The amount of reimbursement must be the same as a Head Start agency's usual and customary cost for each screening component or the maximum fee determined under subpart 1, whichever is lower.

Subp. 3. **Prepaid health plan.** A prepaid health plan is not eligible for a separate payment for screening. The early and periodic screening, diagnosis, and treatment screening must be a service included within the prepaid capitation rate specified in its contract with the department.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

9505.1709 EPSDT SCREENING FORM.

A screening provider must complete and submit to the department an EPSDT screening form for each screening the provider completes. The form must report the findings of the screening and the provider's charge for services.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

9505.1712 TRAINING.

The department must train the staff of an EPSDT clinic that is supervised by a physician on how to comply with the procedures required by part 9505.1718 if the EPSDT clinic requests the training.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

9505.1715 COMPLIANCE WITH SURVEILLANCE AND UTILIZATION REVIEW.

A screening provider must comply with the surveillance and utilization review requirements of parts 9505.2160 to 9505.2245.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

9505.1718 SCREENING STANDARDS FOR AN EPSDT CLINIC.

Subpart 1. **Requirement.** An early and periodic screening, diagnosis, and treatment screening must meet the requirements of subparts 2 to 15 except as provided by part 9505.1706, subpart 2.

Subp. 2. **Health and developmental history.** A history of a child's health and development must be obtained from the child, parent of the child, or an adult who is familiar with the child's health history. The history must include information on sexual development, lead and tuberculosis exposure, nutrition intake, chemical abuse, and social, emotional, and mental health status.

Subp. 3. **Assessment of physical growth.** The child's height or length and the child's weight must be measured and the results plotted on a growth grid based on data from the National Center for Health Statistics (NCHS). The head circumference of a child up to 36 months of age or a child whose growth in head circumference appears to deviate from the expected circumference for that child must be measured and plotted on an NCHS–based growth grid.

Subp. 4. **Physical examination.** The following must be checked according to accepted medical procedures: pulse; respiration; blood pressure; head; eyes; ears; nose; mouth; pharynx; neck; chest; heart; lungs; abdomen; spine; genitals; extremities; joints; muscle tone; skin; and neurological condition.

Subp. 5. **Vision.** A child must be checked for a family history of maternal and neonatal infection and ocular abnormalities. A child must be observed for pupillary reflex; the presence of nystagmus; and muscle balance, which includes an examination for esotropia, exotropia, phorias, and extraocular movements. The external parts of a child's eyes must be examined including the lids, conjunctiva, cornea, iris, and pupils. A child or parent of the child must be asked whether he or she has concerns about the child's vision.

Subp. 6. **Vision of a child age three or older.** In addition to the requirements of subpart 5, the visual acuity of a child age three years or older must be checked by use of the Screening Test for Young Children and Retardates (STYCAR) or the Snellen Alphabet Chart.

Subp. 7. **Hearing.** A child must be checked for a family history of hearing disability or loss, delay of language acquisition or history of such delay, the ability to determine the direction of a sound, and a history of repeated otitis media during early life. A child or parent of the child must be asked whether he or she has any concerns regarding the child's hearing.

Subp. 8. **Hearing of a child age three or older.** In addition to the requirements of subpart 7, a child age three or older must receive a pure tone audiometric test or referral for the test if the examination under subpart 7 indicates the test is needed.

Subp. 9. **Development.** A child must be screened for the following according to the screening provider's standard procedures: fine and gross motor development, speech and language development, social development, cognitive development, and self–help skills. Standardized tests that are used in screening must be culturally sensitive and have norms for the age range tested, written procedures for administration and for scoring and interpretation that are statistically reliable and valid. The provider must use a combination of the child's health and developmental history and standardized test or clinical judgment to determine the child's developmental status or need for further assessment.

Subp. 10. **Sexual development.** A child must be evaluated to determine whether the child's sexual development is consistent with the child's chronological age. A female must receive a breast examination and pelvic examination when indicated. A male must receive a testicular examination when indicated. If it is in the best interest of a child, counseling on normal sexual development, information on birth control and sexually transmitted diseases, and prescriptions and tests must be offered to a child. If it is in the best interest of a child, a screening provider may refer the child to other resources for counseling or a pelvic examination.

Subp. 11. **Nutrition.** When the assessment of a child's physical growth performed according to subpart 3 indicates a nutritional risk condition, the child must be referred for further assessment, receive nutritional counseling, or be referred to a nutrition program such as the Special Supplemental Food Program for Women, Infants, and Children; food stamps; Expanded Food and Nutrition Education Program; or Head Start.

Subp. 12. **Immunizations.** The immunization status of a child must be compared to the "Recommended Schedule for Active Immunization of Normal Infants and Children," current edition. Immunizations that the comparison shows are needed must be offered to the child and given to the child if the child or parent of the child accepts the offer. The "Recommended Schedule for Active Immunization of Normal Infants and Children," current edition, is developed and distributed by the Minnesota Department of Health, 717 Delaware Street Southeast, Minneapolis, Minnesota 55440. The "Recommended Schedule for Active Immunization of Normal Infants and Children," current edition, is incorporated by reference and is available at the State Law Library, Judicial Center, 25 Constitution Avenue, Saint Paul, Minnesota 55155. It is subject to frequent change.

Subp. 13. **Laboratory tests.** Laboratory tests must be done according to items A to F.

A. A Mantoux test must be administered yearly to a child whose health history indicates ongoing exposure to tuberculosis, unless the child has previously tested positive. A child who tests positive must be referred for diagnosis and treatment.

B. A child aged one to five years must initially be screened for lead through the use of either an erythrocyte protoporphyrin (EP) test or a direct blood lead screening test until December 31, 1992. Beginning January 1, 1993, a child age one to five must initially be screened using a direct blood lead screening test. Either capillary or venous blood may be used as the specimen for the direct blood lead test. Blood tests must be performed at a minimum of once at 12 months of age and once at 24 months of age or whenever the history indicates that there are risk factors for lead poisoning. When the result of the EP or capillary blood test is greater than the maximum allowable level set by the Centers for Disease Control of the United States Public Health Service, the child must be referred for a venous blood lead test. A child with a venous blood lead level greater than the maximum allowable level set by the Centers for Disease Control must be referred for diagnosis and treatment.

C. The urine of a child must be tested for the presence of glucose, ketones, protein, and other abnormalities. A female at or near the age of four and a female at or near the age of ten must be tested for bacteriuria.

D. Either a microhematocrit determination or a hemoglobin concentration test for anemia must be done.

E. A test for sickle cell or other hemoglobinopathy, or abnormal blood conditions must be offered to a child who is at risk of such abnormalities and who has not yet been tested. These tests must be provided if accepted or requested by the child or parent of the child. If the tests identify a hemoglobin abnormality or other abnormal blood condition, the child must be referred for genetic counseling.

F. Other laboratory tests such as those for cervical cancer, sexually transmitted diseases, pregnancy, and parasites must be performed when indicated by a child's medical or family history.

Subp. 14. **Oral examination.** An oral examination of a child's mouth must be performed to detect deterioration of hard tissue, and inflammation or swelling of soft tissue. Counseling about the systemic use of fluoride must be given to a child when fluoride is not available through the community water supply or school programs.

Subp. 14a. **Health education and health counseling.** Health education and health counseling concerning the child's health must be offered to the child who is being screened and to the child's parent or representative. The health education and health counseling are for the purposes of assisting the child or the parent or representative of the child to understand the expected growth and development of the child and of informing the child or the parent or representative of the child about the benefits of healthy lifestyles and about practices to promote accident and disease prevention.

Subp. 15. **Schedule of age related screening standards.** An early and periodic screening, diagnosis, and treatment screening for a child at a specific age must include, at a minimum, the screening requirements of subparts 2 to 14 as provided by the following schedule:

Schedule of age related screening standards

A. Infancy:

Standards	Ages					
	By 1 month	2 months	4 months	6 months	9 months	12 months
Health History	X	X	X	X	X	X
Assessment of Physical Growth:						
Height	X	X	X	X	X	X
Weight	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X
Physical Examination	X	X	X	X	X	X
Vision	X	X	X	X	X	X
Hearing	X	X	X	X	X	X
Development	X	X	X	X	X	X
Health Education/ Counseling	X	X	X	X	X	X
Sexual Development	X	X	X	X	X	X
Nutrition	X	X	X	X	X	X
Immunizations/Review		X	X	X	X	X
Laboratory Tests:						
Tuberculin		if history indicates				
Lead Absorption		if history indicates				X
Urinalysis	←	←	←	X	←	←
Hematocrit or Hemoglobin	←	←	←	←	X	X
Sickle Cell		at parent's or child's request				
Other Laboratory Tests		as indicated				
Oral Examination	X	X	X	X	X	X

X = Procedure to be completed.

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

B. Early Childhood:

Standards	Ages				
	15 months	18 months	24 months	3 years	4 years
Health History	X	X	X	X	X
Assessment of Physical Growth:					
Height	X	X	X	X	X
Weight	X	X	X	X	X
Head Circumference	X	X	X	X	X
Physical Examination	X	X	X	X	X
Vision	X	X	X	X	X
Hearing	X	X	X	X	X
Blood Pressure				X	X
Development	X	X	X	X	X

Health Education/Counseling	X	X	X	X	X
Sexual Development	X	X	X	X	X
Nutrition	X	X	X	X	X
Immunizations/Review	X	X	X	X	X
Laboratory Tests:					
Tuberculin	if history indicates				
Lead Absorption	if history indicates		X	if history indicates	
Urinalysis	←	←	X	←	←
Bacteriuria (females)					X
Hematocrit or Hemoglobin	←	←	←	←	←
Sickle Cell	at parent's or child's request				
Other Laboratory Tests	as indicated				
Oral Examination	X	X	X	X	X

X = Procedure to be completed.

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

C. Late childhood:

Standards	Ages				
	5 years	6 years	8 years	10 years	12 years
Health History	X	X	X	X	X
Assessment of Physical Growth:					
Height	X	X	X	X	X
Weight	X	X	X	X	X
Physical Examination	X	X	X	X	X
Vision	X	X	X	X	X
Hearing	X	X	X	X	X
Blood Pressure	X	X	X	X	X
Development	X	X	X	X	X
Health Education/Counseling	X	X	X	X	X
Sexual Development	X	X	X	X	X
Nutrition	X	X	X	X	X
Immunizations/Review	X	X	X	X	X
Laboratory Tests:					
Tuberculin	if history indicates				
Lead Absorption	if history indicates				
Urinalysis	←	←	X	←	←
Bacteriuria (females)	←	←	X	←	←
Hemoglobin or Hematocrit	←	←	X	←	
Sickle Cell	at parent's or child's request				
Other Laboratory Tests	as indicated				
Oral Examination	X	X	X	X	X

X = Procedure to be completed.

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

D. Adolescence:

Standards	Ages 14 years	16 years	18 years	20 years
Health History	X	X	X	X
Assessment of Physical Growth:				
Height	X	X	X	X
Weight	X	X	X	X
Physical Examination	X	X	X	X
Vision	X	X	X	X
Hearing	X	X	X	X
Blood Pressure	X	X	X	X
Development	X	X	X	X
Health Education/Counseling	X	X	X	X
Sexual Development	X	X	X	X
Nutrition	X	X	X	X
Immunizations/Review	X	X	X	X
Laboratory Tests:				
Tuberculin	if history indicates			
Lead Absorption	if history indicates			
Urinalysis	←		X	
Bacteriuria (females)	←		←	
Hemoglobin or Hematocrit	←		X	
Sickle Cell	at parent's or child's request			
Other Laboratory Tests	as indicated			
Oral Examination	X		X	

X = Procedure to be completed.

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

Subp. 15a. **Additional screenings.** A child may have a partial or complete screening between the ages specified in the schedule under subpart 15 if the screening is medically necessary or a concern develops about the child's health or development.

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

History: *13 SR 1150; 16 SR 2518*

9505.1724 PROVISION OF DIAGNOSIS AND TREATMENT.

Diagnosis and treatment identified as needed under part 9505.1718 shall be eligible for medical assistance payment subject to the provisions of parts 9505.0170 to 9505.0475.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

9505.1727 INFORMING.

A local agency must inform each child or parent of a child about the EPSDT program no later than 60 days after the date the child is determined to be eligible for medical assistance. The information about the EPSDT program must be given orally and in writing, indicate the purpose and benefits of the EPSDT program, indicate that the EPSDT program is without cost to the child or parent of the child while the child is eligible for medical assistance, state

the types of medical and dental services available under the EPSDT program, and state that the transportation and appointment scheduling assistance required under part 9505.1730 is available.

The department must send a written notice to a child or parent of a child who has been screened informing the child or parent that the child should be screened again. This notice must be sent at the following ages of the child: six months, nine months, one year, 18 months, two years, four years, and every three years after age four.

Each year, on the date the child was determined eligible for medical assistance entitlements, the department must send a written notice to a child or parent of a child who has never been screened informing the child or parent that the child is eligible to be screened.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

9505.1730 ASSISTANCE WITH OBTAINING A SCREENING.

Within ten working days of receiving a request for screening from a child or parent of a child, a local agency must give or mail to the child or parent of the child:

A. a written list of EPSDT clinics in the area in which the child lives; and

B. a written offer of help in making a screening appointment and in transporting the child to the site of the screening.

If the child or parent of the child requests help, the local agency must provide it.

Transportation under this item must be provided according to part 9505.0140, subpart 1.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

9505.1733 ASSISTANCE WITH OBTAINING DIAGNOSIS AND TREATMENT.

An EPSDT clinic must notify a child or parent of a child who is referred for diagnosis and treatment that the local agency will provide names and addresses of diagnosis and treatment providers and will help with appointment scheduling and transportation to the diagnosis and treatment provider. The notice must be on a form provided by the department and must be given to the child or parent of the child on the day the child is screened.

If a child or parent of a child asks a local agency for assistance with obtaining diagnosis and treatment, the local agency must provide that assistance within ten working days of the date of the request.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

9505.1736 SPECIAL NOTIFICATION REQUIREMENT.

A local agency must effectively inform an individual who is blind or deaf, or who cannot read or understand the English language, about the EPSDT program.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

9505.1739 CHILDREN IN FOSTER CARE.

Subpart 1. **Dependent or neglected state wards.** The local agency must provide early and periodic screening, diagnosis, and treatment services for a child in foster care who is a dependent or neglected state ward under parts 9560.0410 to 9560.0470, and who is eligible for medical assistance unless the early and periodic screening, diagnosis, and treatment services are not in the best interest of the child.

Subp. 2. **Other children in foster care.** The local agency must discuss the EPSDT program with a parent of a child in foster care who is under the legal custody or protective supervision of the local agency or whose parent has entered into a voluntary placement agreement with the local agency. The local agency must help the parent decide whether to accept early and periodic screening, diagnosis, and treatment services for the child. If a parent cannot be consulted, the local agency must decide whether to accept early and periodic screening, diagnosis, and treatment services for the child and must document the reasons for the decision.

Subp. 3. **Assistance with appointment scheduling and transportation.** The local agency must help a child in foster care with appointment scheduling and transportation for screening, diagnosis, and treatment as provided by parts 9505.1730 to 9505.1733.

Subp. 4. **Notification.** The department must send a written notice to the local agency stating that a child in foster care who has been screened should be screened again. This notice must be sent at the following ages of the child: six months, nine months, one year, 18 months, two years, four years, and every three years thereafter.

Each year, by the anniversary of the date the child was determined eligible for medical assistance entitlements, the department must send a written notice to the local agency that a child in foster care who has never been screened is eligible to be screened.

If a written notice under this subpart pertains to a child who is a dependent or neglected state ward, the local agency must proceed according to subpart 1. The local agency must proceed according to subpart 2 if the written notice pertains to a child who is not a dependent or neglected state ward.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

9505.1742 DOCUMENTATION.

The local agency must document compliance with parts 9505.1693 to 9505.1748 on forms provided by the department.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

9505.1745 INTERAGENCY COORDINATION.

The local agency must coordinate the EPSDT program with other programs that provide health services to children as provided by Code of Federal Regulations, title 42, section 441.61(c), as amended through October 1, 1986. Examples of such agencies are a public health nursing service, a Head Start agency, and a school district.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

9505.1748 CONTRACTS FOR ADMINISTRATIVE SERVICES.

Subpart 1. **Authority.** A local agency may contract with a county public health nursing service, a community health clinic, a Head Start agency, a community action agency, or a school district for early and periodic screening, diagnosis, and treatment administrative services. Early and periodic screening, diagnosis, and treatment administrative services include outreach; notification; appointment scheduling and transportation; follow–up; and documentation. For purposes of this subpart, "community action agency" means an entity defined in Minnesota Statutes, section 268.53, subdivision 1, and "school district" means a school district as defined in Minnesota Statutes, section 120.02, subdivisions 13 to 15.

Subp. 2. **Federal financial participation.** The percent of federal financial participation for salaries, fringe benefits, and travel of skilled professional medical personnel and their supporting staff shall be paid as provided by Code of Federal Regulations, title 42, section 433.15(b)(5), as amended through October 1, 1986.

Subp. 3. **State reimbursement.** State reimbursement for contracts for EPSDT administrative services under this part shall be as provided by Minnesota Statutes, section 256B.19, subdivision 1, except for the provisions under subdivision 1 that pertain to a prepaid health plan.

Subp. 4. **Approval.** A contract for administrative services must be approved by the local agency and submitted to the department for approval by November 1 of the year before the beginning of the calendar year in which the contract will be effective. A contract must contain items A to L to be approved by the department for reimbursement:

A. names of the contracting parties;

B. purpose of the contract;

C. beginning and ending dates of the contract;

D. amount of the contract, budget breakdown, and a clause that stipulates that the department's procedures for certifying expenditures will be followed by the local agency;

E. the method by which the contract may be amended or terminated;

F. a clause that stipulates that the contract will be renegotiated if federal or state program regulations or federal financial reimbursement regulations change;

G. a clause that stipulates that the contracting parties will provide program and fiscal records and maintain all nonpublic data required by the contract according to the Minnesota Government Data Practices Act and will cooperate with state and federal program reviews;

H. a description of the services contracted for and the agency that will perform them;

I. methods by which the local agency will monitor and evaluate the contract;

J. signatures of the representatives of the contracting parties with the authority to obligate the parties by contract and dates of those signatures;

K. a clause that stipulates that the services provided under contract must be performed by or under the supervision of skilled medical personnel; and

L. a clause that stipulates that the contracting parties will comply with state and federal requirements for the receipt of medical assistance funds.

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

History: *13 SR 1150; 16 SR 2518*

9505.1750 [Repealed, 15 SR 2563]

9505.1760 [Repealed, 15 SR 2563]

9505.1770 [Repealed, 15 SR 2563]

9505.1780 [Repealed, 15 SR 2563]

9505.1790 [Repealed, 15 SR 2563]

9505.1800 [Repealed, 15 SR 2563]

9505.1810 [Repealed, 15 SR 2563]

9505.1820 [Repealed, 15 SR 2563]

9505.1830 [Repealed, 15 SR 2563]

9505.1840 [Repealed, 15 SR 2563]

9505.1850 [Repealed, 15 SR 2563]

9505.1860 [Repealed, 15 SR 2563]

9505.1870 [Repealed, 15 SR 2563]

9505.1880 [Repealed, 15 SR 2563]

9505.1890 [Repealed, 15 SR 2563]

9505.1900 [Repealed, 15 SR 2563]

9505.1910 [Repealed, 15 SR 2563]

9505.1920 [Repealed, 15 SR 2563]

9505.1930 [Repealed, 15 SR 2563]

9505.1940 [Repealed, 15 SR 2563]

9505.1950 [Repealed, 15 SR 2563]

9505.1960 [Repealed, 15 SR 2563]

9505.1970 [Repealed, 15 SR 2563]

9505.1980 [Repealed, 15 SR 2563]

9505.1990 [Repealed, 15 SR 2563]

9505.2000 [Repealed, 15 SR 2563]

9505.2010 [Repealed, 15 SR 2563]

9505.2020 [Repealed, 15 SR 2563]

9505.2030 [Repealed, 15 SR 2563]

9505.2040 [Repealed, 15 SR 2563]

9505.2050 [Repealed, 15 SR 2563]

9505.2060 [Repealed, 15 SR 2563]

9505.2070 [Repealed, 15 SR 2563]

9505.2080 [Repealed, 15 SR 2563]

9505.2090 [Repealed, 15 SR 2563]

9505.2100 [Repealed, 15 SR 2563]

9505.2110 [Repealed, 15 SR 2563]

9505.2120 [Repealed, 15 SR 2563]

9505.2130 [Repealed, 15 SR 2563]

9505.2140 [Repealed, 15 SR 2563]

9505.2150 [Repealed, 15 SR 2563]

SURVEILLANCE AND UTILIZATION REVIEW PROGRAM

9505.2160 SCOPE AND APPLICABILITY.

Subpart 1. **Scope.** Parts 9505.2160 to 9505.2245 govern procedures to be used by the department in identifying and investigating fraud, theft, or abuse by providers or recipients of health services through the medical assistance, general assistance medical care, consolidated chemical dependency treatment, children's health plan, catastrophic health expense protection programs, home and community–based services under a waiver from the Health Care Financing Administration of the United States Department of Health and Human Services, or any other health service program administered by the department, and for the imposition of sanctions against providers and recipients of health services. Additionally, parts 9505.2160 to 9505.2245 establish standards applicable to the health service and financial records of providers of health services through medical assistance, general assistance medical care, consolidated chemical dependency treatment, children's health plan, or catastrophic health expense protection programs.

Parts 9505.2160 to 9505.2245 must be read in conjunction with titles XVIII and XIX of the Social Security Act; Code of Federal Regulations, title 42; Minnesota Statutes, chapters 62E, 145, 245, 245A, 252, 253, 254A, 254B, 256, 256B, 256D, 256E, and 609.

Subp. 2. **Applicability.** Parts 9505.2160 to 9505.2245 apply to local agencies, providers participating in a program, and recipients of health services through a program.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2165 DEFINITIONS.

Subpart 1. **Scope.** The terms in parts 9505.2160 to 9505.2245 shall have the meanings given them in this part and in part 9505.0175, the medical assistance definitions.

Subp. 2. **Abuse.** "Abuse" means:

A. in the case of a provider, a pattern of practices that is inconsistent with sound fiscal, business, or health service practices, and that result in unnecessary costs to the pro-

grams, or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health service. The following practices are deemed to be abuse by a provider:

(1) submitting repeated claims from which required information is missing or incorrect;

(2) submitting repeated claims using procedure codes which overstate the level or amount of health service provided;

(3) submitting repeated claims for health services which are not reimbursable under the programs;

(4) submitting repeated duplicate claims for the same health service provided to the same recipient;

(5) submitting repeated claims for health services that do not comply with part 9505.0210 and, if applicable, part 9505.0215;

(6) repeated submission of claims for services that are not medically necessary;

(7) failing to develop and maintain health service records as required under part 9505.2175;

(8) failing to use generally accepted accounting principles or other accounting methods which relate entries on the recipient's health service record to corresponding entries on the billing invoice, unless another accounting method or principle is required by federal or state law or rule;

(9) failing to disclose or make available to the department the recipient's health service records or the provider's financial records as required by part 9505.2180;

(10) repeatedly failing to properly report duplicate payments from third party payers for covered services provided to a recipient under a program and billed to the department;

(11) failing to obtain information and assignment of benefits as specified in part 9505.0070, subpart 3, or to bill Medicare as required by part 9505.0440;

(12) failing to keep financial records as required under part 9505.2180;

(13) repeatedly submitting or causing repeated submission of false information for the purpose of obtaining prior authorization, inpatient hospital admission certification under parts 9505.0500 to 9505.0540, or a second surgical opinion as required under part 9505.5035;

(14) knowingly and willfully submitting a false or fraudulent application for provider status;

(15) soliciting, charging, or receiving payments from recipients or nonmedical assistance sources, in violation of Code of Federal Regulations, title 42, section 447.15, or part 9505.0225, for services for which the provider has received reimbursement from or should have billed to the program;

(16) payment by a provider of program funds to a vendor whom the provider knew or had reason to know was suspended or terminated from program participation;

(17) repeatedly billing a program for services after entering into an agreement with a third–party payer to accept an amount in full satisfaction of the payer's liability; or

B. in the case of a recipient, the use of health services that results in unnecessary costs to the programs, or in reimbursements for services that are not medically necessary. The following practices are deemed to be abuse by a recipient:

(1) obtaining equipment, supplies, drugs, or health services that are in excess of program limitations or that are not medically necessary and that are paid for through a program;

(2) obtaining duplicate services for the same health condition from a multiple number of providers. Duplicate service does not include an additional opinion that is medically necessary for the diagnosis, evaluation, or assessment of the recipient's condition or required under program rules, or a service provided by a school district as specified in the

recipient's individualized education plan under Minnesota Statutes, section 256B.0625, subdivision 26;

(3) continuing to engage in practices that are abusive of the program after receiving the department's written warning that the conduct must cease;

(4) altering or duplicating the medical identification card for the purpose of obtaining additional health services billed to the program or aiding another person to obtain such services;

(5) using a medical identification card that belongs to another person;

(6) using the medical identification card to assist an unauthorized individual in obtaining a health service for which a program is billed;

(7) duplicating or altering prescriptions;

(8) misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, health services, or drugs;

(9) furnishing incorrect eligibility status or information to a provider;

(10) furnishing false information to a provider in connection with health services previously rendered to the recipient which were billed to a program; or

(11) obtaining health service by false pretenses.

Subp. 3. **Federal share.** "Federal share" means the percent of federal financial participation in the cost of the state's medical assistance program.

Subp. 4. **Fraud.** "Fraud" means medical assistance fraud as defined in Minnesota Statutes, section 609.466.

Subp. 5. **Health services.** "Health services" has the meaning given in part 9505.0175, subpart 14.

Subp. 6. **Health service record.** "Health service record" means written or diagrammed documentation of the nature, extent, and evidence of the medical necessity of a health service provided to a recipient by a provider and billed to a program.

Subp. 6a. **Medically necessary or medical necessity.** "Medically necessary" or "medical necessity" has the meaning given in part 9505.0175, subpart 25.

Subp. 6b. **Pattern.** "Pattern" means an identifiable series of more than one event or activity.

Subp. 7. **Primary care case manager.** "Primary care case manager" means a provider designated by the department who is a physician or a group of physicians, who is employed by or under contract with the Department of Human Services, and who is responsible for the direct care of a recipient, and for coordinating and controlling access to or initiating or supervising other health care services needed by the recipient.

Subp. 8. **Program.** "Program" means the Minnesota medical assistance program, the general assistance medical care program, catastrophic health expense protection program, children's health plan, consolidated chemical dependency program, home and community–based services under a waiver from the Health Care Financing Administration of the United States Department of Health and Human Services, or any other health service program administered by the department.

Subp. 9. **Provider.** "Provider" has the meaning given in part 9505.0175, subpart 38.

Subp. 10. **Recipient.** "Recipient" means an individual who has been determined eligible to receive health services under a program.

Subp. 11. **Restriction.** "Restriction" means:

A. in the case of a provider, excluding or limiting the scope of the health services for which a provider may receive a payment through a program for a reasonable time; or

B. in the case of a recipient, limiting the recipient's participation in a program for a period of 24 months, to only health services which have been prior authorized, or to health services from a designated primary care case manager or other designated health service providers. The restriction of a recipient must be indicated on the recipient's medical identification card or other form of program identification, under part 9505.0145, subpart 4. For purposes of restriction, designated health service providers do not include long–term care facilities.

Subp. 12. **Suspending participation or suspension.** "Suspending participation" or "suspension" means making a provider ineligible for reimbursement by a program for a stated period of time.

Subp. 13. **Suspending payments.** "Suspending payments" means stopping any or all program payments for health services billed by a provider pending resolution of the matter in dispute between the provider and the department.

Subp. 14. **Terminating participation.** "Terminating participation" means making a provider ineligible for reimbursement by a program.

Subp. 15. **Theft.** "Theft" means the act defined in Minnesota Statutes, section 609.52, subdivision 2, clause (3)(c).

Subp. 16. **Third–party payer.** "Third–party payer" means the term defined in part 9505.0015, subpart 46, and, additionally, Medicare.

Subp. 17. **Withholding payments.** "Withholding payments" means reducing or adjusting the amounts paid to a provider to offset overpayments previously made to the provider.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563; 16 SR 960*

9505.2175 HEALTH SERVICE RECORDS.

Subpart 1. **Documentation requirement.** As a condition for payment by a program, a provider must document each occurrence of a health service provided to a recipient. The health service must be documented in the recipient's health service record as specified in subpart 2 and, when applicable, subparts 3 to 6. Program funds paid for a health service not documented in a recipient's health service record shall be recovered.

Subp. 2. **Required standards for health service records.** A provider must keep a health service record as specified in items A to I.

A. The record must be legible at a minimum to the individual providing care.

B. The recipient's name must be on each page of the recipient's record.

C. Each entry in the health service record must contain:

(1) the date on which the entry is made;

(2) the date or dates on which the health service is provided;

(3) the length of time spent with the recipient if the amount paid for the service depends on time spent;

(4) the signature and title of the person from whom the recipient received the service; and

(5) when applicable, the countersignature of the provider or the supervisor as required under parts 9505.0170 to 9505.0475.

D. The record must state:

(1) the recipient's case history and health condition as determined by the provider's examination or assessment;

(2) the results of all diagnostic tests and examinations; and

(3) the diagnosis resulting from the examination.

E. The record must show the quantity, dosage, and name of prescribed drugs ordered for or administered to the recipient.

F. The record must contain reports of consultations that are ordered for the recipient.

G. The record must contain the recipient's plan of care, individual treatment plan, or individual program plan. For purposes of this item, "plan of care" has the meaning given in part 9505.0175, subpart 35; "individual treatment plan" has the meaning given in part 9505.0477, subpart 14; and "individual program plan" has the meaning given in part 9535.0100, subpart 15.

H. The record must report the recipient's progress or response to treatment, and changes in the treatment or diagnosis.

I. The record of a laboratory or X–ray service must document the provider's order for service.

Subp. 3. **Requirements for pharmacy service records.** A pharmacy service record must comply with the requirements of subparts 1 and 2 and Minnesota Rules, part 6800.3110, relating to pharmacy licensing and operations, and Minnesota Rules, part 6800.3950, relating to electronic data processing of pharmacy records. However, the pharmacy service record must be a hard copy made at the time of the request for service and must be kept for five years as required under part 9505.2190, subpart 1.

Subp. 4. **Requirements for medical transportation service records.** A medical transportation record must meet the requirements of subparts 1 and 2 and must document:

A. the origin, destination, and distance traveled in providing the service to the recipient;

B. the type of transportation; and

C. if applicable, a physician's certification for nonemergency, ancillary, or special transportation services as defined in part 9505.0315, subpart 1, items A and F.

Subp. 5. **Requirements for medical supplies and equipment records.** A medical supplies and equipment record must meet the requirements of subparts 1 and 2 and:

A. must document that the medical supply or equipment meets the criteria in parts 9505.0210 and 9505.0310; and

B. except as provided in part 9505.2190, subpart 1, must contain a hard copy of the provider's order or prescription for the medical supply or equipment and the name and amount of the medical supply or equipment provided for the recipient.

Subp. 6. **Requirements for rehabilitative and therapeutic services.** Rehabilitative and therapeutic service records must meet the requirements of subparts 1 and 2 and must meet the criteria in part 9505.0412.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2180 FINANCIAL RECORDS.

Subpart 1. **Financial records required of providers.** The financial records of a provider who receives payment for a recipient's services under a program must contain the material specified in items A to H:

A. payroll ledgers, canceled checks, bank deposit slips and any other accounting records prepared for the provider;

B. contracts for services or supplies that relate to the provider's costs and billings to a program for the recipient's health services;

C. evidence of the provider's charges to recipients and to persons who are not recipients, consistent with the requirements of Minnesota Statutes, chapter 13;

D. evidence of claims for reimbursement, payments, settlements, or denials resulting from claims submitted to third–party payers or programs;

E. the provider's appointment books for patient appointments and the provider's schedules for patient supervision, if applicable;

F. billing transmittal forms;

G. records showing all persons, corporations, partnerships, and entities with an ownership or control interest in the provider as defined in Code of Federal Regulations, title 42, section 455.101; and

H. employee records for those persons currently employed by the provider or who have been employed by the provider at any time within the previous five years which under the Minnesota Government Data Practices Act would be considered public data for a public employee such as employee name, salary, qualifications, position description, job title, and dates of employment; and in addition employee records shall include the current home address of the employee or the last known address of any former employee.

Subp. 2. **Additional financial records required for long–term care facilities.** A long–term care facility must maintain:

A. the records required under subpart 1;

B. purchase invoices; and

C. records of the deposits and expenditure of funds in the recipients' resident fund accounts as required under part 9505.0425.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2185 ACCESS TO RECORDS.

Subpart 1. **Recipient's consent to access.** A recipient of medical assistance is deemed to have authorized in writing a provider or others to release to the department for examination according to Minnesota Statutes, section 256B.27, subdivision 4, upon the department's request, the medical assistance recipient's health service records related to services under a program. The medical assistance recipient's authorization of the release and review of health service records for services provided while the person is a medical assistance recipient shall be presumed competent if given in conjunction with the person's application for medical assistance. This presumption shall exist regardless of whether the application was signed by the person or the person's guardian or authorized representative as defined in part 9505.0015, subpart 8.

Subp. 2. **Department access to provider records.** A provider shall grant the department access during the provider's regular business hours to examine health service and financial records related to a health service billed to a program. Access to a recipient's health service record shall be for the purposes in part 9505.2200, subpart 1. The department shall notify the provider no less than 24 hours before obtaining access to a health service or financial record, unless the provider waives notice.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2190 RETENTION OF RECORDS.

Subpart 1. **Retention required; general.** A provider shall retain a health service and financial record related to a health service for which payment under a program was received or billed for at least five years after the initial date of billing. Microfilm records satisfy the record keeping requirements of this subpart and part 9505.2175, subpart 3, in the fourth and fifth years after the date of billing.

Subp. 2. **Record retention after provider withdrawal or termination.** A provider who withdraws or is terminated from a program must retain or make available to the department on demand the health service and financial records required under subpart 1.

Subp. 3. **Record retention under change of ownership.** If the ownership of a long-term care facility or provider service changes, the transferor, unless otherwise provided by law or written agreement with the transferee, is responsible for maintaining, preserving, and making available to the department on demand the health service and financial records related to services generated before the date of the transfer as required under subpart 1 and part 9505.2185, subpart 2.

Subp. 4. **Record retention in contested cases.** In the event of a contested case, the provider must retain health service and financial records as required by subpart 1 or for the duration of the contested case proceedings, whichever period is longer.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2195 COPYING RECORDS.

The department, at its own expense, may photocopy or otherwise duplicate any health service or financial record related to a health service for which a provider makes a claim or receives payment under a program. Photocopying shall be done on the provider's premises unless removal is specifically permitted by the provider. If a provider fails to allow the department to use the department's equipment to photocopy or duplicate any health service or financial record on the premises, the provider must furnish copies at the provider's expense within two weeks of a request for copies by the department.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2200 IDENTIFICATION AND INVESTIGATION OF SUSPECTED FRAUD AND ABUSE.

Subpart 1. **Department investigation.** The department shall investigate providers or recipients to monitor compliance with program requirements for the purposes of identifying fraud, theft, or abuse in the administration of the programs.

Subp. 2. **Contacts to obtain information.** The department may contact any person, agency, organization, or other entity that is necessary to an investigation under subpart 1. Among those who may be contacted are:

A. government agencies;

B. third–party payers, including Medicare;

C. professional review organizations as defined in Minnesota Statutes, section 145.61, subdivision 5, or their representatives;

D. a professional services advisory committee established under part 9505.0185 or its representative;

E. recipients and their responsible relatives;

F. providers and persons employed by or under contract to providers;

G. professional associations of providers and their peers;

H. recipients and recipient advocacy organizations; and

I. members of the public.

Subp. 3. **Activities included in department's investigation.** The department's authority to investigate extends to the examination of any person, document, or thing which is likely to lead to information relevant to the expenditure of funds, provision of services, or purchase of items identified in part 9505.2160, subpart 1, provided that the information sought is not privileged against such an investigation by operation of any state or federal law. Among the activities which the department's investigation may include are as follows:

A. examination of health service and financial records;

B. examination of equipment, materials, prescribed drugs, or other items used in or for a recipient's health service under a program;

C. examination of prescriptions for recipients;

D. interviews of contacts specified in subpart 2;

E. verification of the professional credentials of a provider, the provider's employees, and entities under contract with the provider to provide health services or maintain health service and financial records related to a program;

F. consultation with the department's peer review mechanisms; and

G. determination of whether a health service provided to a recipient meets the criteria of parts 9505.0210 and 9505.0215.

Subp. 4. **Determination of investigation.** After completing its investigation under subparts 1 to 3, the department shall determine whether:

A. the provider or the recipient is in compliance with the requirements of a program;

B. insufficient evidence exists that fraud, theft, or abuse has occurred; or

C. the evidence of fraud, theft, or abuse supports administrative, civil, or criminal action.

Subp. 5. **Postinvestigation action.** After completing the determination required under subpart 4, the department shall take one or more of the actions specified in items A to F:

A. close the investigation when no further action is warranted;

B. impose administrative sanctions according to part 9505.2210;

C. seek monetary recovery according to part 9505.2215;

D. refer the investigation to the appropriate state regulatory agency;

E. refer the investigation to the attorney general or, if appropriate, to a county attorney for possible civil or criminal legal action; or

F. issue a warning that states the practices are potentially in violation of program laws or regulations.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2205 COMMISSIONER TO DECIDE IMPOSITION OF SANCTION.

The commissioner shall decide what sanction shall be imposed against a provider or recipient under part 9505.2210. The commissioner shall consider the recipient's personal preferences in the designation of a primary care case manager. In addition, the commissioner shall consider the following factors in determining the sanctions to be imposed:

A. nature and extent of fraud, theft, or abuse;

B. history of fraud, theft, or abuse;

C. willingness of provider or recipient to comply with program rules;

D. actions taken or recommended by other state regulatory agencies; and

E. in the case of a recipient, the local trade area and access to medically necessary services in the designation of a primary care case manager or other restrictions.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2210 IMPOSITION OF ADMINISTRATIVE SANCTIONS.

Subpart 1. **Authority to impose administrative sanction.** The commissioner shall impose administrative sanctions or issue a warning letter if the department's investigation under part 9505.2200 determines the presence of fraud, theft, or abuse in connection with a program or if the provider or recipient refuses to grant the department access to records as required under part 9505.2185.

Subp. 2. **Nature of administrative sanction.** The actions specified in items A and B are administrative sanctions that the commissioner may impose for the conduct specified in subpart 1.

A. For a provider, the actions are:

(1) referral to the appropriate peer review mechanism;

(2) transfer to a provider agreement of limited duration;

(3) transfer to a provider agreement which stipulates specific conditions of participation;

(4) suspending or terminating the provider's participation;

(5) requiring attendance at provider education sessions provided by the department;

(6) requiring prior authorization of the provider's services;

(7) review of the provider's claims before payment; and

(8) restricting the provider's participation in a program.

B. For a recipient, except as provided in subpart 3, the actions are:

(1) referral for appropriate health counseling to correct inappropriate or dangerous use of health care services;

(2) restriction of the recipient; and

(3) referral to the appropriate adult or child protection agency.

Subp. 3. **Emergency health services excepted from restrictions.** Emergency health services provided to a restricted recipient by a provider shall be eligible for payment by a program if the service provided is otherwise eligible for payment by a program. The department may require the provider to provide documentation of the emergency circumstance with the emergency service payment claim.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2215 MONETARY RECOVERY.

Subpart 1. **Authority to seek monetary recovery.** The commissioner shall seek monetary recovery:

A. from a provider, if payment for a recipient's health service under a program was the result of fraud, theft, or abuse, or error on the part of the provider, department, or local agency; or

B. from a recipient, if payment for a health service provided under a program was the result of fraud, theft, or abuse, or error on the part of the recipient absent a showing that recovery would, in that particular case, be unreasonable or unfair.

Subp. 2. **Methods of monetary recovery.** The commissioner shall recover money described in subpart 1 by the following means:

A. permitting voluntary repayment of money, either in lump sum payment or installment payments;

B. using any legal collection process;

C. deducting or withholding from program payments money described in subpart 1; and

D. withholding payments to a provider under Code of Federal Regulations, title 42, section 447.31.

Subp. 3. **Interest charges on monetary recovery.** If the department permits the use of installment payments to repay money described in subpart 1, the department may assess interest on the funds to be received at the rate established by the Department of Revenue under Minnesota Statutes, section 270.75. Interest may accrue from the effective date of recovery, as specified in part 9505.2230, subpart 2.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2220 USE OF RANDOM SAMPLE EXTRAPOLATION IN MONETARY RECOVERY.

Subpart 1. **Authorization.** For the purpose of part 9505.2215, the commissioner shall be authorized to calculate the amount of monetary recovery from a provider of money erroneously paid based upon extrapolation from systematic random samples of claims submitted by the provider and paid by the program or programs. The department's random sample extrapolation shall constitute a rebuttable presumption regarding the calculation of monetary recovery. If the presumption is not rebutted by the provider in the appeal process, the department shall use the extrapolation as the monetary recovery figure specified in subpart 3.

Subp. 2. **Decision to use samples.** The department shall decide whether sampling and extrapolation are to be used in calculating a monetary recovery according to the following criteria:

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.

Subp. 3. **Sampling method.** The department shall use the methods in items A to D in calculating the amount of monetary recovery by random sample extrapolation.

A. Samples of a given size shall be selected in such a way that every sample of that size shall be equally likely to be selected.

B. Samples shall only be selected from claims for health services provided within the interval that coincides with the interval during which money allegedly was erroneously provided and for which recovery will be made.

C. The sampling method, including sample size, sample selections, and extrapolation from the results of the sample, shall be according to statistical procedures published in the following text: W. Cochran, Sampling Techniques, John Wiley and Sons, New York 3rd Ed. (1977). Sampling Techniques is incorporated by reference and is available through the Minitex interlibrary loan system.

D. The sample size will be sufficiently large so that the estimate of the amount which would be recovered by a full audit will be within five percent of that amount with 95 percent confidence. A two–sided 95 percent confidence interval for that amount will be computed. The department's calculated monetary recovery is the lower end of that confidence interval.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2225 SUSPENSION OF PROVIDER CONVICTED OF CRIME RELATED TO MEDICARE OR MEDICAL ASSISTANCE.

The commissioner shall suspend a provider who has been convicted of a crime related to Medicare or medical assistance as provided in Minnesota Statutes, sections 256B.064 and 256D.03, subdivision 7, clause (b). The procedures in part 9505.0475 shall be followed in the suspension process.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2230 NOTICE OF AGENCY ACTION.

Subpart 1. **Required written notice.** The department shall give notice in writing to a provider or recipient of a monetary recovery or administrative sanction that is to be imposed by the department. The notice shall be sent by first class mail. The department shall place an affidavit of the mailing in the provider's or recipient's file as an indication of the date of mailing and the address. The notice shall state:

A. the factual basis for the department's determination according to part 9505.2200, subpart 4;

B. the actions the department plans to take;

C. the dollar amount of the monetary recovery, if any;

D. how the dollar amount was computed;

E. the right to dispute the department's determinations and to provide evidence; and

F. the right to appeal the department's proposed action under part 9505.2245.

Subp. 2. **Effective date of recovery or sanction.** For providers, the effective date of the proposed monetary recovery or sanction shall be the first day after the last day for requesting an appeal as provided in part 9505.2245, subpart 1, item B. For recipients, the effective date of the proposed action shall be 30 days after the recipient's receipt of the notice required under subpart 1. If an appeal is made under part 9505.2245, the proposed action shall be delayed pending the final outcome of the appeal, except as provided by part 9505.2231. Implementation of a proposed action following the resolution of an appeal may be postponed if in the opinion of the commissioner the delay of action is necessary to protect the health or safety of the recipient or recipients.

Subp. 3. **Effect of department's administrative determination.** Unless a timely and proper appeal made under part 9505.2245 is received by the department, the administrative determination of the department shall be considered final and binding.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2231 SUSPENSION OR WITHHOLDING OF PAYMENTS TO PROVIDERS BEFORE APPEAL.

Subpart 1. **Grounds for suspension or withholding.** The commissioner is authorized to suspend or withhold payments to a provider before an appeal provided in part 9505.2245, if:

A. there is substantial likelihood that the department will prevail in an action under parts 9505.2160 to 9505.2245;

B. there is a substantial likelihood that the provider's practice, which is the basis for the department's determination made under part 9505.2200, subpart 4, will continue in the future;

C. there is reasonable cause to doubt the provider's financial ability to repay the amount determined to be due; or

D. suspending participation or withholding payment is necessary to comply with Minnesota Statutes, section 256B.064, subdivision 2.

Subp. 2. **Exception to prehearing suspension or withholding.** The commissioner shall not order a prehearing suspension or withholding of payments to a nursing home or convalescent care facility.

Subp. 3. **Federal share.** When an overpayment has been made by the department, the commissioner is authorized to recover from a provider the federal share when it is due to the federal government under federal law and regulations.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2235 SUSPENSION OR TERMINATION OF PROVIDER PARTICIPATION.

Subpart 1. **Effect of suspension or termination as provider.** The provider agreement of a vendor who is under suspension or terminated from participation shall be void from the date of the suspension or termination. A suspension or termination from medical assistance does not mean suspension or termination from another program unless the suspension or termination is extended to that program. The vendor who is under suspension or terminated from participation shall not submit a claim for payment under a program, either through a claim as an individual or through a claim submitted by a clinic, group, corporation, or professional association except in the case of claims for payment for health services provided before the vendor's suspension or termination from participation. No payments shall be made to a vendor, either directly or indirectly, for services provided under a program from which the vendor had been suspended or terminated.

Subp. 2. **Reinstatement of vendor as provider.** A vendor who is under suspension or terminated from participation is eligible to apply for reinstatement as a provider at the end of the period of suspension or when the basis for termination no longer exists. The department shall review a vendor's application to determine whether the vendor is qualified to participate as specified by the provider participation requirements of part 9505.0195 and Code of Federal Regulations, title 42, sections 1002.230 to 1002.234.

Subp. 3. **Prohibited submission of vendor's claims.** A clinic, group, corporation, or other professional association shall not submit a claim for a health service under a program provided by a vendor who is under suspension or terminated from participation unless the health service was provided before the vendor's suspension or termination. If a clinic, group, corporation, or other professional association receives payment under a program for a health service provided by a vendor after the vendor's suspension or termination from participation, the department shall recover the amount of the payment and may impose administrative sanctions against the clinic, group, corporation, or other professional association if the commissioner determines that the provider knew or had reason to know of the suspension or termination.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2236 RESTRICTION OF PROVIDER PARTICIPATION.

Subpart 1. **Effect of restriction on a provider.** The provider agreement of a provider who is restricted from participation shall be amended by the restriction specified in the notice of action to the vendor provided under part 9505.2230. The provider who is restricted from participation shall not submit a claim for payment under a program for services or charges specified in the notice of action, either through a claim as an individual or through a claim submitted by a clinic, group, corporation, or professional association, except in the case of claims for payment for health services otherwise eligible for payment and provided before the restriction. No payments shall be made to a provider, either directly or indirectly, for restricted services or charges specified in the notice of action.

Subp. 2. **Reinstatement of restricted provider.** A provider who is restricted from participation is eligible to apply for reinstatement as an unrestricted provider at the end of the period of restriction. The department shall review a provider's application to determine whether the provider is qualified to participate without restrictions as specified by the provider participation requirements of part 9505.0195 and Code of Federal Regulations, title 42, sections 1002.230 to 1002.234.

Subp. 3. **Prohibited submission of restricted provider's claims.** A clinic, group, corporation, or other professional association shall not submit a claim for a health service furnished under a program by a provider who is restricted from furnishing the health service or submitting a charge or claim, unless the health service was provided before the provider's

restriction. If a clinic, group, corporation, or other professional association receives payment for a health service furnished under a program by a provider restricted from participation, the department shall recover the amount of the payment and may impose administrative sanctions against the clinic, group, corporation, or other professional association if the commissioner determines that the clinic, group, corporation, or other professional association knew or had reason to know of the restriction.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2240 NOTICE TO THIRD PARTIES ABOUT DEPARTMENT ACTIONS FOLLOWING INVESTIGATION.

Subpart 1. **Notice about providers.** After the department has taken an action against a provider as specified in part 9505.2210, subpart 2, item A, and the right to appeal has been exhausted or the time to appeal has expired, the department shall issue the notices required in items A and B.

A. The department shall notify the appropriate professional society, board of registration or licensure, and federal or state agencies of the findings made, sanctions imposed, appeals made, and the results of any appeal.

B. The department shall notify the general public about action taken under part 9505.2210, subpart 2, item A, subitem (4) or (8), by publishing the notice in a general circulation newspaper in the geographic area of Minnesota generally served by the provider in the majority of its health services to Minnesota program recipients. The notice shall include the provider's name and service type, the action taken by the department, and the effective date or dates of the action.

Subp. 2. **Information and notice about recipients.** After the department has taken an action against a recipient as specified in part 9505.2210, subpart 2, item B, subitem (2), and the recipient's right to appeal has been exhausted or the time to appeal has expired, the department must notify the recipient's primary care case manager and other health care providers about the restriction imposed on the recipient and the circumstances leading to the restriction. Notice shall include the recipient's name and program, the nature of the restriction imposed on the recipient, a list of providers to whom the recipient is restricted, and the beginning and ending dates of the restriction.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2245 APPEAL OF DEPARTMENT ACTION.

Subpart 1. **Provider's right to appeal.** A provider may appeal the department's proposed actions under parts 9505.2210, 9505.2215, and 9505.2220, under the provisions of Minnesota Statutes, section 14.57 to 14.62.

A. The appeal request shall specify:

(1) each disputed item, the reason for the dispute, and estimate of the dollar amount involved for each disputed item;

(2) the computation that the provider believes is correct;

(3) the authority in the statute or rule upon which the provider relies for each disputed item; and

(4) the name and address of the person or entity with whom contacts may be made regarding the appeal.

B. An appeal shall be considered timely if written notice of appeal is received by the commissioner as provided by statute.

Subp. 2. **Recipient's right to appeal.** A recipient may appeal any sanction proposed by the department under Minnesota Statutes, section 256.045, and part 9505.0130.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2250 [Repealed, 13 SR 258]

9505.2260 [Repealed, 13 SR 258]

9505.2270 [Repealed, 13 SR 258]

9505.2280 [Repealed, 13 SR 258]

9505.2290 [Repealed, 13 SR 258]

9505.2300 [Repealed, 13 SR 258]

9505.2310 [Repealed, 13 SR 258]

9505.2320 [Repealed, 13 SR 258]

9505.2330 [Repealed, 13 SR 258]

9505.2340 [Repealed, 13 SR 258]

9505.2350 [Repealed, 13 SR 258]

9505.2360 [Repealed, 13 SR 258]

9505.2370 [Repealed, 13 SR 258]

9505.2380 [Repealed, 13 SR 258]

PREADMISSION SCREENING AND ALTERNATIVE CARE GRANT PROGRAM

9505.2390 SCOPE AND EFFECT.

Subpart 1. **Scope.** Parts 9505.2390 to 9505.2500 establish the standards and procedures applicable to the preadmission screening and alternative care grant program. The preadmission screening program screens persons who are applicants for admission to a nursing home or nursing home residents who request a screening as required under part 9505.2435, subpart 2. An alternative care grant pays for some community services in lieu of nursing home admission or continued nursing home resident status for persons who meet the requirements of parts 9505.2390 to 9505.2500.

Parts 9505.2390 to 9505.2500 must be read in conjunction with Minnesota Statutes, sections 256B.04, subdivision 2, 256B.05, 256B.091, subdivisions 1 to 9, and Code of Federal Regulations, title 42, sections 440.180 and 441.300 to 441.310. Unless otherwise specified, citations of Code of Federal Regulations, title 42, refer to the code amended as of October 1, 1986.

Parts 9505.2390 to 9505.2500 also must be read in conjunction with the requirements of the waiver obtained by the state from the United States Department of Health and Human Services.

Subp. 2. **Effect.** References to the waiver and waiver provisions that occur in parts 9505.2390 to 9505.2500 shall continue in effect only as long as the waiver from the United States Department of Health and Human Services remains in effect in Minnesota.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2395 DEFINITIONS.

Subpart 1. **Applicability.** The definitions in this part apply to parts 9505.2390 to 9505.2500.

Subp. 2. **Adult day care services.** "Adult day care services" means services provided to alternative care grant clients by adult day care programs established under Minnesota Statutes, sections 245A.01 to 245A.17, including adult day care centers licensed under parts 9555.9600 to 9555.9730.

Subp. 3. **Adult foster care services.** "Adult foster care services" means supervised living arrangements for adults in an adult foster care home licensed under parts 9555.5105 to 9555.6265.

Subp. 4. **Alternative care grant or ACG.** "Alternative care grant" or "ACG" means funds allocated to a local agency by the commissioner under Minnesota Statutes, section 256B.091 to pay for alternative care services.

Subp. 5. **Alternative care grant client or ACG client.** "Alternative care grant client" or "ACG client" means a person who has been determined eligible to receive or is receiving services funded by an alternative care grant.

Subp. 6. **Alternative care grant services.** "Alternative care grant services" means the services listed in items A to G provided to ACG clients:

A. case management services;

B. respite care services;

C. homemaker services;

D. home health aide services;

E. adult foster care services;

F. adult day care services; and

G. personal care services.

Subp. 7. **Applicant.** "Applicant" means a person who is seeking admission to a nursing home or who has been admitted to a nursing home but has not yet been screened by the preadmission screening team as required in part 9505.2420.

Subp. 8. **Assessment form.** "Assessment form" means the form supplied by the commissioner that is used to record the information required under parts 9505.2425, subpart 1 and 9505.2455, subpart 12.

Subp. 9. **Case management services.** "Case management services" means services that identify, acquire, authorize, and coordinate services for an ACG client; monitor the delivery of services to the ACG client; and adjust services to the needs of the ACG client.

Subp. 10. **Case manager.** "Case manager" means a social worker employed by or under contract with the local agency or a registered nurse who is employed by the local public health department and under contract with the local agency to provide case management services. "Local agency" in this subpart refers to the county of service.

Subp. 11. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or the commissioner's authorized representative.

Subp. 12. **Community services.** "Community services" means home and community based services including services provided under the ACG as specified in part 9505.2430, subpart 4, item B, subitem (3), that can be used to meet the health or social needs of an ACG client.

Subp. 13. **County of financial responsibility.** "County of financial responsibility" means the county responsible for paying for preadmission screening of a recipient or the county responsible for paying for ACG services under part 9505.2455, subpart 3.

Subp. 14. **County of service.** "County of service" means the county whose local agency performs preadmission screening of an applicant or nursing home resident or arranges case management services for an ACG client. The county of service may be the same as or different from the county of financial responsibility.

Subp. 15. **Delay of screening.** "Delay of screening" means that preadmission screening has not been completed for an applicant but will be completed according to the time requirements established for:

A. emergency admission under part 9505.2420, subpart 3;

B. preadmission screening of hospital patients under part 9505.2420, subpart 2;

C. 30 day exemption from screening under part 9505.2420, subpart 4; or

D. admission of an applicant from another state under part 9505.2420, subpart 6.

Subp. 16. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 17. **Directory of services.** "Directory of services" means the list of all community services available in a geographic area that is developed under part 9505.2425, subpart 7.

Subp. 18. **Discharge planner.** "Discharge planner" means a person qualified as a public health nurse or a social worker who is employed by a hospital to coordinate the development of an individual service plan of a person who no longer needs the services of the hospital.

Subp. 19. **Emergency admission.** "Emergency admission" means the admission of an applicant from the community to a nursing home before completion of preadmission screen-

ing when a physician has determined that the delay in admission needed for preadmission screening would adversely affect the applicant's health and safety. For purposes of this definition, "community" does not include a hospital.

Subp. 20. **Formal caregivers.** "Formal caregivers" means persons or entities providing ACG services who are employed or who are under contract with a local agency, or other agency or organization, public or private.

Subp. 21. **Home health aide.** "Home health aide" means a person who meets the requirements of part 9505.2470 and provides home health aide services to an ACG client.

Subp. 22. **Home health aide services.** "Home health aide services" means services provided under part 9505.2470 that are written in the individual treatment plan. Home health aide services include the performance of procedures as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self administered, reporting changes in the ACG client's condition and needs, and completing necessary records.

Subp. 23. **Homemaker services.** "Homemaker services" means services that assist an ACG client as set forth in items A to G:

A. performing house cleaning activities;

B. laundering, ironing, and mending;

C. meal planning, preparation, and cleanup;

D. assisting with money management;

E. providing companionship, emotional support, and social stimulation;

F. observing and evaluating home safety practices and seeking to improve these practices where appropriate; and

G. performing essential errands and shopping.

Subp. 24. **Hospital.** "Hospital" has the definition given in Minnesota Statutes, section 144.696, subdivision 3.

Subp. 25. **Individual service plan.** "Individual service plan" means the written plan of a community service or a combination of community services designed to meet the health and social needs of an applicant or nursing home resident screened according to part 9505.2430. The individual service plan is the plan of care referred to in Minnesota Statutes, section 256B.091.

Subp. 26. **Individual treatment plan.** "Individual treatment plan" means the written treatment plan of care for providing personal care and home health aide services under part 9505.2475 to an ACG client.

Subp. 27. **Informal caregivers.** "Informal caregivers" means family, friends, neighbors, or others who provide services and assistance to the elderly without the sponsorship of an agency or organization.

Subp. 28. **Local agency.** "Local agency" means the county or multicounty agency that is required under Minnesota Statutes, section 256B.05, to administer the medical assistance program.

Subp. 29. **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. 30. **Mental illness.** "Mental illness" means an illness as defined in Minnesota Statutes, section 245.462, subdivision 20, clause (2).

Subp. 31. **Nursing home.** "Nursing home" means a facility licensed under Minnesota Statutes, chapter 144A or sections 144.50 to 144.56, that is certified to participate in the medical assistance program as a skilled nursing facility or an intermediate care facility. This definition includes boarding care homes.

Subp. 32. **Nursing home resident.** "Nursing home resident" means a person who resides, and expects to continue to reside, in a nursing home for more than 30 days. For purposes of parts 9505.2390 to 9505.2500, "nursing home resident" does not include a person who is in a nursing home for respite care.

Subp. 33. **Personal care services.** "Personal care services"means services meeting the requirements of part 9505.2465.

Subp. 34. **Personal care assistant.** "Personal care assistant" means a person who provides personal care services under part 9505.2465 and meets the training requirements of part 9505.2465, subpart 2.

Subp. 35. **Person with mental retardation or related conditions.** "Person with mental retardation or related conditions" means a person as defined in part 9525.0015, subpart 20.

Subp. 36. **Physician.** "Physician" means a person who is authorized to practice medicine under Minnesota Statutes, chapter 147.

Subp. 37. **Preadmission screening.** "Preadmission screening" means the activities performed by a preadmission screening team under Minnesota Statutes, section 256B.091, and parts 9505.2390 to 9505.2500. This definition does not include the activities of teams authorized under Minnesota Statutes, section 256B.092, and established in parts 9525.0015 to 9525.0165 and under the Minnesota Comprehensive Mental Health Act, Minnesota Statutes, sections 245.461 to 245.486.

Subp. 38. **Preadmission screening document.** "Preadmission screening document" means the document required in part 9505.2495, subpart 1, and supplied by the commissioner.

Subp. 39. **Preadmission screening team.** "Preadmission screening team" means the team authorized in Minnesota Statutes, section 256B.091, and required by part 9505.2410, to assess the financial, health, and social needs of an applicant or a nursing home resident.

Subp. 40. **Primary caregiver.** "Primary caregiver" means the informal caregiver who customarily provides care to the ACG client and cooperates with the case manager in assuring the provision of services by the formal caregivers.

Subp. 41. **Public health nurse.** "Public health nurse" means a registered nurse certified by the Minnesota Department of Health as a public health nurse under Minnesota Statutes, section 145A.02, subdivision 18, and employed by a local board of health under Minnesota Statutes, section 145A.10, subdivision 1.

Subp. 42. **Public health nursing services.** "Public health nursing services" means the nursing program provided by a board of health under Minnesota Statutes, section 145A.10, subdivision 1.

Subp. 43. **Reassessment.** "Reassessment" means the reevaluation of an ACG client's financial, health, and social needs under part 9505.2455, subparts 11 and 12.

Subp. 44. **Recipient.** "Recipient" means a person who has been determined by the local agency to be eligible for medical assistance under parts 9505.0010 to 9505.0150.

Subp. 45. **Registered nurse.** "Registered nurse" means a person licensed under Minnesota Statutes, section 148.211.

Subp. 46. **Representative.** "Representative" means a person appointed by the court as a guardian or conservator under Minnesota Statutes, sections 252A.01 to 252A.21 or 525.539 to 525.6198 or a parent of a child under age 18 unless the parent's parental rights have been terminated.

Subp. 47. **Rescreening.** "Rescreening" means the completion of the activities in part 9505.2435, subpart 3, after an initial preadmission screening.

Subp. 48. **Resident class.** "Resident class" refers to the case mix classification required under Minnesota Statutes, section 256B.091, subdivision 2, and assigned to a person as required under parts 9549.0058, subpart 2, and 9549.0059.

Subp. 49. **Resident day.** "Resident day" means a day for which nursing services in a nursing home are rendered or a day for which a nursing home bed is held.

Subp. 50. **Respite care services.** "Respite care services" means short term supervision, assistance, and care provided to an ACG client due to the temporary absence or need for relief of the ACG client's primary caregiver. Respite care services may be provided in the client's home or in a facility approved by the state such as a hospital, nursing home, foster home, or community residential facility.

Subp. 51. **Room and board costs.** "Room and board costs" means costs associated with providing food and shelter to a person, including the directly identifiable costs of:

A. private and common living space;

B. normal and special diet food preparation and service;

C. linen, bedding, laundering, and laundry supplies;

D. housekeeping, including cleaning and lavatory supplies;

E. maintenance and operation of the building and grounds, including fuel, electricity, water, supplies, and parts and tools to repair and maintain equipment and facilities; and

F. allocation of salaries and other costs related to items A to E.

Subp. 52. **Skilled nursing service.** "Skilled nursing service" refers to the term described in Code of Federal Regulations, title 42, section 405.1224.

Subp. 53. **Social worker.** "Social worker" means a person who has met the minimum qualifications of a social worker under the Minnesota Merit System or a county civil service system in Minnesota.

Subp. 54. **Unscreened applicant.** "Unscreened applicant" means an applicant for whom preadmission screening has not been completed under parts 9505.2390 to 9505.2500.

Subp. 55. **Waiver.** "Waiver" means the approval given by the United States Department of Health and Human Services which allows the state to pay for home and community based services authorized under Code of Federal Regulations, title 42, section 441, subpart G. The term includes all amendments to the waiver including any amendments made after August 8, 1988, as approved by the United States Department of Health and Human Services.

Subp. 56. **Working day.** "Working day" means the hours of a day, excluding Saturdays, Sundays, and holidays, when a local agency is open for business.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2396 COMPUTATION OF TIME INTERVALS TO MEET NOTICE REQUIREMENTS.

For purposes of parts 9505.2390 to 9505.2500, a required time interval to meet notice requirements must be computed to exclude the first and include the last day of the prescribed interval of time. The term "day" includes Saturday, Sunday, and holidays unless it is modified as "working day."

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2400 PREADMISSION SCREENING REQUIREMENT.

Subpart 1. **Coverage.** The preadmission screening team established by the local agency must complete the preadmission screening of all applicants except individuals who are exempt under subpart 2 and the preadmission screening of current nursing home residents who request a screening. The preadmission screening team shall complete the screening as specified in part 9505.2425, except in the cases of persons with mental retardation or related conditions. Persons with mental retardation or related conditions must be provided services according to parts 9525.0015 to 9525.0165. Persons with mental illness must be provided services according to the Minnesota Comprehensive Mental Health Act, Minnesota Statutes, sections 245.461 to 245.486.

Subp. 2. **Exemptions.** The following individuals are exempt from the requirement of subpart 1:

A. a nursing home resident who transfers from one nursing home located within Minnesota directly to another nursing home located within Minnesota, regardless of the location of either nursing home;

B. a nursing home resident who is admitted to a hospital from a nursing home and who returns to a nursing home;

C. a nursing home resident who changes certified levels of care within the same nursing home;

D. an applicant for whom preadmission screening was completed within the previous three months;

E. an applicant who has been screened and who is currently receiving ACG services;

F. an applicant who has been screened and who is currently receiving services from a certified home health agency;

G. an applicant who is not eligible for medical assistance and whose length of residency in a nursing home is expected to be 30 days or less as determined under part 9505.2420, subpart 4;

H. an applicant whose nursing home care is paid for indefinitely by the United States Veterans Administration;

I. an applicant who enters a nursing home administered by and for the adherents of a recognized church or religious denomination described in Minnesota Statutes, section 256B.091, subdivision 4; and

J. an applicant to a nursing home described in Minnesota Statutes, section 256B.431, subdivision 4, paragraph (c).

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2405 INFORMATION REGARDING AVAILABILITY OF PREADMISSION SCREENING.

The local agency must annually publish a notice that preadmission screening is available to persons in the area served by the local agency. At a minimum, the notice must appear in the newspaper that has the largest circulation within the geographic area served by the local agency. The notice must:

A. explain the purpose of preadmission screening as stated in Minnesota Statutes, section 256B.091, subdivision 1;

B. instruct the public how to contact the preadmission screening team; and

C. state who is subject to and who may request preadmission screening under Minnesota Statutes, section 256B.091, subdivisions 2 and 4, and part 9505.2400.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2410 ESTABLISHMENT OF PREADMISSION SCREENING TEAM.

Subpart 1. **Establishment.** A local agency must establish at least one preadmission screening team to complete preadmission screening of applicants and nursing home residents. In addition, a local agency may contract with a nonprofit hospital to perform the functions of a preadmission screening team under part 9505.2413 for applicants being discharged from the hospital. If a nonprofit hospital performs the functions of a preadmission screening team under contract with a local agency, the hospital's discharge planner shall not be a member of the team unless the applicant is a person being discharged from the hospital. If a nonprofit hospital does not have a contract with the local agency to perform the functions of a screening team, the hospital's discharge planner may be present at the preadmission screenings and may participate in the discussions but not in making the screening team's recommendations.

Subp. 2. **Composition of preadmission screening team.** A preadmission screening team must be composed as specified in items A to C.

A. The preadmission screening team must include a social worker and a public health nurse. The team must also include the applicant's or nursing home resident's physician if the physician chooses to participate.

B. The social worker of the local agency's preadmission screening team must be employed by or under contract with the local agency and must be designated by name as a member of the preadmission screening team.

C. If a local agency has a human services board organized under Minnesota Statutes, sections 402.01 to 402.10, the local agency must designate by name the public health nurse member of the preadmission screening team. If a local agency does not have a human services board organized under Minnesota Statutes, sections 402.01 to 402.10, the local agency must contract with the board of health organized under Minnesota Statutes, section 145.913, or a public or nonprofit agency under contract with the local agency to provide pub-

lic health nursing services to provide the public health nurse member of the preadmission screening team. The local board of health or a public or nonprofit agency under contract with the local agency to provide public health nursing services must designate by name the public health nurse member of a preadmission screening team.

Subp. 3. **Number of preadmission screening team members present at screening.** Except as provided in subpart 5, the social worker and the public health nurse designated as members of the preadmission screening team must be present at a preadmission screening. The applicant's or nursing home resident's physician may be present if the physician chooses to participate in the preadmission screening.

Subp. 4. **Physician notification of preadmission screening.** The local agency must notify the physician of the applicant or nursing home resident being screened, by telephone, of the date, time, and place the person's preadmission screening is to take place. The telephone notice must be made on the day that the preadmission screening team schedules the screening. The notice must state the physician's right to participate as a member of the preadmission screening team. No later than ten working days after the telephone notice, the local agency must send the physician a written notice that contains the information given in the telephone notice.

Subp. 5. **Preadmission screening by public health nurse.** Preadmission screening may be completed by the public health nurse member of the team, in consultation with the social worker, for applicants who are being admitted to a nursing home from a hospital and who are not eligible for medical assistance under parts 9505.0010 to 9505.0150. For the purpose of this subpart, "consultation" means a meeting or telephone conversation between the public health nurse and the social worker that takes place after the public health nurse has completed the preadmission screening. The purpose of the consultation is to discuss the assessment, the recommendation, and, as appropriate, the applicant's individual service plan or the applicant's plans for discharge from the nursing home.

Subp. 6. **Physician consultant to preadmission screening team.** A local agency must designate a physician who practices within the local agency's service area to serve as a consultant to the preadmission screening teams designated under subpart 2.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2413 CONTRACTS FOR PREADMISSION SCREENING TEAM MEMBERS FOR APPLICANTS DISCHARGED FROM HOSPITALS.

The local agency may contract with a nonprofit hospital to provide one or both members of a preadmission screening team to screen applicants being discharged from the nonprofit hospital and to make recommendations for the screened applicants about nursing home admission and community services necessary for the applicant's individual service plan. The contract between the local agency and the nonprofit hospital must:

A. set beginning and ending dates of the contract;

B. specify the duties and responsibilities of the local agency and the nonprofit hospital;

C. specify that a member of the preadmission screening team to be provided by the hospital must be a discharge planner;

D. designate by name the person or persons to be provided by the hospital;

E. require the designated preadmission screening team member or members to comply with parts 9505.2390 to 9505.2500;

F. specify that the member or members of the preadmission screening team under contract will screen only applicants being discharged from that nonprofit hospital;

G. designate the person employed by the hospital and the person employed by the local agency who are responsible for proper performance under the contract;

H. state that the nonprofit hospital must complete a preadmission screening for an applicant before the applicant's discharge from the nonprofit hospital;

I. require that a member of the nonprofit hospital's screening team have no direct or indirect financial or self–serving interest in a nursing home or other referral such that it would not be possible for the member to consider each case objectively;

J. specify the amount the local agency must pay the nonprofit hospital for carrying out the terms of the contract;

K. specify the person employed by the hospital who is responsible for implementing appropriate data practices; and

L. specify reports and records to be kept by the nonprofit hospital.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2415 HOSPITAL NOTICE REQUIREMENTS.

Subpart 1. **Notification of preadmission screening team.** Except as indicated under subpart 2, the discharge planner of a hospital must notify the preadmission screening team about a hospital patient who is an applicant. Oral and written notices must be given. The oral notice must be given to the preadmission screening team at least three working days before discharge of the applicant. The hospital must document the oral notice by sending the preadmission screening team a written notice within ten working days after the oral notice. The notice must:

A. provide the name of the applicant;

B. provide the name of the nursing home that the applicant is considering;

C. provide the applicant's primary diagnosis;

D. indicate the interval in which the applicant is expected to be discharged from the nursing home. The intervals are: less than 30 consecutive days; 30 days but less than three months; three months but less than six months; or six months or more;

E. indicate that the discharge planner gave information to the applicant about the purpose of preadmission screening and community services; and

F. indicate if the discharge planner wants to participate in the preadmission screening.

Subp. 2. **Exception to notice required of hospital.** If the applicant is in the hospital for less than three working days and preadmission screening is not completed, the hospital may discharge the applicant to a nursing home, but the hospital discharge planner must contact the preadmission screening team by telephone or in person before the applicant's discharge and complete the notice required under subpart 1.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2420 TIME REQUIREMENTS FOR PREADMISSION SCREENING.

Subpart 1. **General time requirements.** Except as provided in subparts 2 to 6, the local agency must schedule a preadmission screening within five working days of receiving a request for the preadmission screening from an applicant or an applicant's representative. Except as provided in subparts 2 to 6, the preadmission screening must be completed within the period of ten working days following the applicant's request for preadmission screening.

Subp. 2. **Preadmission screening of hospital patients.** Notwithstanding subpart 1, the local agency must complete the preadmission screening of an applicant who is a hospital patient within three working days of receiving oral notice from the discharge planner under part 9505.2415, subpart 1. However, the local agency may delay the preadmission screening of an applicant who is a hospital patient when, based on information given in the oral notice, the preadmission screening cannot be completed before discharge from the hospital and the applicant's discharge plan indicates that the applicant must be admitted to a nursing home. If preadmission screening is delayed and the local agency and the nursing home are located in the same county, the local agency must notify the nursing home orally and in writing of the scheduled date for the preadmission screening and perform the preadmission screening within ten working days after the applicant's admission to the nursing home.

If preadmission screening is delayed and the nursing home and the local agency are located in different counties, the local agency of the county in which the nursing home is located must be responsible for the preadmission screening. The local agency of the county in which the hospital is located must send an oral and a written notice of the applicant's dis-

charge plan to the local agency in the county where the nursing home is located. Oral notice must be given on the day that the local agency of the county in which the hospital is located delays preadmission screening. The written notice must be sent within ten working days after the oral notice. The written notice must include a copy of the delay of screening form completed by the local agency of the county in which the hospital is located and a copy of the hospital's discharge notice. The preadmission screening team from the local agency in the county where the nursing home is located must then notify the nursing home orally and in writing of the scheduled date for the preadmission screening and perform the preadmission screening within ten working days after the applicant's admission to the nursing home.

Subp. 3. **Emergency admission.** When preadmission screening is not completed due to an emergency admission, the procedures in items A to C must be followed.

A. The attending physician must certify the reason for the emergency in the applicant's medical record.

B. The nursing home must orally notify the preadmission screening team within two working days after the date of the emergency admission.

C. The preadmission screening team must complete the preadmission screening of the applicant within ten working days of the date of the applicant's admission to the nursing home or within ten working days after receiving the oral referral for preadmission screening, whichever is earlier.

Subp. 4. **Thirty day exemption from preadmission screening.** A local agency must grant a 30 day exemption from preadmission screening to applicants who are not eligible for medical assistance if the requirements in items A and B are met.

A. The nursing home must notify the local agency of the applicant's admission no later than the day of the applicant's admission to the nursing home. The notice must include information stating that the requirements of item B have been met.

B. The attending physician must certify in the applicant's medical record in the nursing home that the applicant's expected length of stay in the nursing home will be 30 consecutive days or less.

The preadmission screening team of the local agency that has determined that the applicant's request for a 30 day exemption from preadmission screening meets the requirements in items A and B must complete and send the nursing home a form supplied by the commissioner authorizing the 30 day exemption and at the same time must send a copy of the form to the applicant.

The nursing home must provide an update to the preadmission screening team before or on the 30th day of the applicant's stay if the applicant will continue to live in the nursing home for more than 30 consecutive days. The local agency must complete preadmission screening within ten working days after the 30th day unless the applicant is discharged within these ten working days, does not return to the nursing home, and does not become an applicant to a different nursing home.

Subp. 5. **Nursing home applicant admitted to a hospital from a nursing home before completion of preadmission screening.** The local agency must complete preadmission screening of a nursing home applicant who has been admitted to a nursing home within the periods required under subparts 1 to 4 unless the nursing home applicant is admitted to a hospital during these periods. If a nursing home applicant is admitted to a hospital during the periods under subparts 1 to 4, the preadmission screening time requirements begin again on the date of readmission to the nursing home.

Subp. 6. **Applicant from another state.** When an applicant from another state is admitted to a nursing home in Minnesota, the nursing home must notify the preadmission screening team within two working days after the date of the admission. The notice may be oral or written. The preadmission screening team must then complete the preadmission screening of the applicant within ten working days after the date of admission to the nursing home.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2425 SCREENING AND ASSESSMENT PROCEDURES REQUIRED DURING PREADMISSION SCREENING.

Subpart 1. **General requirements.** The preadmission screening team must assess the health and social needs of the applicant or nursing home resident being screened using the assessment form provided by the commissioner. The preadmission screening team must carry out the responsibilities specified in subparts 2 to 14 and the duties listed in part 9505.0295, subpart 3, item C. The preadmission screening team must ask whether the person being screened has been determined eligible for or is receiving medical assistance and must give a person whose eligibility for medical assistance has not been determined information about making a medical assistance application.

Subp. 2. **Assessment interview.** The preadmission screening team must conduct the assessment in a face–to–face interview with the person being screened and the person's representative, if any.

Subp. 3. **Information given to person being screened by screening team during preadmission screening.** The preadmission screening team must give the person being screened or the person's representative the form or forms supplied by the commissioner containing the information specified in items A to E:

A. the purpose of the preadmission screening and alternative care grant program under Minnesota Statutes, section 256B.091;

B. the person's freedom to accept or reject the recommendation of the preadmission screening team;

C. the person's right to confidentiality under the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13;

D. the person's right to appeal the preadmission screening team's recommendation under part 9505.2500 and Minnesota Statutes, sections 256.045, subdivisions 2 and 3 and 256B.091, subdivision 5; and

E. if the person is not a recipient, the right of the person and the person's spouse to retain liquid assets up to the amount specified in Minnesota Statutes, sections 256B.14, subdivision 2; 256B.17; and 256B.48.

The preadmission screening team must document compliance with this subpart by signing and placing in the local agency's records of the person being screened the forms supplied by the commissioner that state the required information was given to the person being screened.

Subp. 4. **Access to medical records.** The preadmission screening team must ask the person being screened or the person's representative to sign forms necessary to authorize the team's access to the person's medical records. Furthermore, a nursing home or a hospital's discharge planner that conducts a preadmission screening must ask the person being screened or the person's representative to sign forms necessary to authorize the team's access to information that is needed to complete preadmission screening for the person. If the person or the person's representative agrees to sign the forms, the authorization must be completed as prescribed in subpart 14.

Subp. 5. **Preadmission screening team recommendations.** After completing the assessment form required in subpart 1, the preadmission screening team must offer the person being screened or the person's representative the most cost effective alternatives available to meet the person's needs and must recommend one of the choices specified in items A to E.

A. The preadmission screening team must recommend admission to a nursing home for an applicant or continued stay for a nursing home resident when the assessment indicates that the applicant or nursing home resident requires community services that are not available or that the anticipated cost of providing the required community services would exceed the annual monthly statewide average payment of the resident class under parts 9549.0050 to 9549.0059 that would be applicable to the person being screened if the person were placed in a nursing home, calculated from the payments made for that resident class in the previous fiscal year.

B. The preadmission screening team must recommend use of community services when the assessment indicates that the community services needed by the person are available and the anticipated cost of providing the community services is less than the total annual

statewide monthly average payment of the resident class under parts 9549.0050 to 9549.0059 that would be applicable to the person if the person were placed in a nursing home, calculated from the payments made for that resident class in the previous fiscal year.

C. The preadmission screening team must recommend that the person live in the community without community services if the assessment indicates that the person does not need either admission to a nursing home or community services.

D. A preadmission screening team that has reason to believe that a person being screened has or may have a diagnosis of mental retardation or related conditions must refer the person for services including screening, development of the individual service plan, and case management services according to parts 9525.0015 to 9525.0165.

E. A preadmission screening team that has reason to believe that a person being screened has been diagnosed or may be diagnosed as mentally ill must refer the person for a diagnostic assessment as defined in Minnesota Statutes, section 245.462, subdivision 9. If the person is determined by the diagnostic assessment to have serious and persistent mental illness as defined in Minnesota Statutes, section 245.462, subdivision 20, and the person chooses community services under an ACG, the preadmission screening team must establish the individual service plan as required in part 9505.2430, subpart 4, and assure the assignment of a case manager as specified in part 9505.2430, subpart 6. The case manager shall incorporate the person's individual community support plan as defined in Minnesota Statutes, section 245.462, subdivision 12, into the person's individual service plan and shall coordinate the person's services that are specified in the Comprehensive Mental Health Act, Minnesota Statutes, sections 245.461 to 245.486.

Subp. 6. **Required application for ACG services.** If the person being screened chooses to remain in the community with community services the preadmission screening team must request the person or the person's representative to sign an application for the community services under the ACG. To be eligible to receive the community services under the ACG, the person being screened or the person's representative must sign the application. The application shall be on a form prescribed by the commissioner.

Subp. 7. **Use of directory of services during preadmission screening.** The preadmission screening team must use a directory of services provided by the local agency during the preadmission screening in determining the individual service plan of a person being screened. The local agency must make a directory of services available to the preadmission screening team, the person being screened, and other persons present at a screening. The local agency may compile its own directory of services or use a directory prepared by a community resource. In either event, the directory must be one that is updated annually.

Subp. 8. **Notification of preadmission screening team recommendation.** The preadmission screening team must give or send a written notice stating the team's recommendation to the person being screened, the person's representative, if any, and the person's physician. The preadmission screening team must also send the written notice to the county of financial responsibility. Both types of notice must be given or sent within ten working days after the date of the request for the preadmission screening.

Subp. 9. **Individual service plan.** The preadmission screening team must develop an individual service plan according to part 9505.2430 when the person or the person's representative chooses to use community services.

Subp. 10. **Submittal of ACG client information to county of financial responsibility.** If the county of service is different from the county of financial responsibility for an ACG client, the county of service must submit client information to the county of financial responsibility for approval of the individual service plan. The information must include items A to D:

A. the original individual service plan;

B. the original signed application if required under subpart 6;

C. the original preadmission screening document; and

D. a copy of the completed financial information form required in part 9505.2455, subpart 1, item C.

Subp. 11. **County of financial responsibility review of individual service plan.** The county of financial responsibility for an ACG client under part 9505.2455, subpart 3, must

approve or reject the proposed individual service plan under items A to E and part 9505.2455, subpart 2.

A. If the costs of ACG services, together with the costs of skilled nursing services provided by public health nursing services that are reimbursable under medical assistance, if applicable, do not exceed the cost limitations in subpart 5, item B, the county of financial responsibility must approve the proposed individual service plan. If the cost of ACG services together with the costs of skilled nursing services provided by public health nursing services that are reimbursable under medical assistance exceeds the cost limitations in subpart 5, item B, the county of financial responsibility must reject the individual service plan. Rejection of an individual service plan by the county of financial responsibility shall occur only if cost limitations of subpart 5, item B, are not met. If the county of financial responsibility and the county of service are the same, the county shall not reject the individual service plan prepared by the county's preadmission screening team if the individual service plan falls within the cost limitations of subpart 5, item B.

B. The county of financial responsibility must orally notify the preadmission screening team of the approval or rejection of the individual service plan within three working days after receiving the plan from the county of service. The county of financial responsibility must mail a written notice to the preadmission screening team within ten working days after receiving the individual service plan.

C. If the individual service plan is approved by the county of financial responsibility, the county of service must implement the plan upon oral notice of approval from the county of financial responsibility.

D. If the individual service plan is rejected by the county of financial responsibility because it exceeds the cost limitations in subpart 5, item B, the oral and written notice of rejection sent to the preadmission screening team must explain the reasons for the rejection and define the corrections needed to obtain approval. The preadmission screening team must develop a revised individual service plan for an ACG client whose initial individual service plan was rejected by the county of financial responsibility. The preadmission screening team must send the revised individual service plan to the county of financial responsibility within ten days after receiving the oral rejection.

E. If the revised individual service plan includes ACG services that meet the cost limitations in subpart 5, item B, the county of financial responsibility must approve the individual service plan and orally notify the preadmission screening team of the approval within three working days after receiving the revised plan. The county of financial responsibility must send a written notice of approval to the preadmission screening team within ten working days after receiving the revised plan.

Subp. 12. **Sending individual service plan to county of service.** If the county of financial responsibility approves an individual service plan, the preadmission screening team must send the written individual service plan to the county of service within ten working days after the approval.

Subp. 13. **Resident class assessment.** The preadmission screening team must complete the resident class assessment of the applicant required under parts 9549.0058 and 9549.0059 for an applicant who is not exempt from preadmission screening under part 9505.2400, subpart 5, or 9549.0059, subpart 1, item A, subitem (2). The resident class assessment shall be completed concurrently with preadmission screening performed within the time requirements of part 9505.2420.

Subp. 14. **Authorization to release information.** When a preadmission screening team, nursing home, or hospital's discharge planner asks a person being screened or the person's representative to sign forms needed to have access to information necessary to complete the preadmission screening, the following information must be on the form above the person's signature:

A. the person's name;

B. the date;

C. the information authorized;

D. who is authorized to give the information;

E. to whom the information is to be given;

F. the information's use during the screening to determine the appropriateness of nursing home admission or continued nursing home placement or use of community services for the person; and

G. the date of expiration of the authorization.

A separate form must be completed and signed for each authorization of access to a medical record. The period of the authorization must not exceed one year.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2426 APPLICANT'S AND NURSING HOME RESIDENT'S RIGHT TO CHOOSE COMMUNITY SERVICES.

After completion of the preadmission screening required under part 9505.2425, subpart 5, or the rescreening required under part 9505.2435, the applicant, nursing home resident, or the representative of the applicant or nursing home resident shall decide whether to accept or reject the recommendations of the preadmission screening team. If the applicant, nursing home resident, or the representative of the applicant or nursing home resident who is eligible for ACG services decides to receive the ACG services identified in his or her individual service plan, the applicant, nursing home resident, or the representative of the applicant or nursing home resident shall have the freedom to choose among the ACG providers under contract with the local agency to provide the identified ACG services.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2430 ESTABLISHMENT OF INDIVIDUAL SERVICE PLAN.

Subpart 1. **Individual service plan required.** The preadmission screening team must establish an individual service plan for each applicant or nursing home resident who requests preadmission screening and who has been assessed under part 9505.2425, and who has chosen community services except persons referred under part 9505.2425, subpart 5, items D and E. The preadmission screening team must consult the applicant or nursing home resident or the person's representative in establishing the plan. Additionally, the preadmission screening team must ask the applicant or the nursing home resident or the representative of the applicant or nursing home resident whether he or she chooses to have other persons consulted about the plan. The preadmission screening team must consult the persons that the applicant, nursing home resident, or the representative of the applicant or nursing home resident has designated by name to be consulted about the plan.

Subp. 2. **Request for information about eligibility for medical assistance or 180 day eligibility determination.** The preadmission screening team must ask the applicant, nursing home resident, or the representative of the applicant or nursing home resident whether the applicant or nursing home resident receives medical assistance, is a recipient, or would be eligible to receive medical assistance within 180 days after admission to a nursing home. If the preadmission screening team has reason to believe the person being screened would be eligible to receive medical assistance within 180 days after admission to a nursing home, the preadmission screening team must estimate what the person's financial eligibility would be 180 days after admission using a form prescribed by the commissioner.

Subp. 3. **Individual service plan for a person not eligible for an ACG.** The individual service plan prepared by the preadmission screening team for a person being screened who is not eligible for an ACG must document compliance with items A to D:

A. the preadmission screening team determined that the person is not eligible for community services funded by an ACG under part 9505.2455, subpart 2;

B. the preadmission screening team discussed with the person the community services identified as needed in the assessment under part 9505.2425;

C. the preadmission screening team told the person what information is available in the directory of services; and

D. the preadmission screening team gave a copy of the individual service plan to the person.

Subp. 4. **Individual service plan for a person who is eligible for an ACG.** The individual service plan prepared by the preadmission screening team for a person being screened

who is eligible for an ACG must document compliance with items A to D. The person or the person's representative and a member of the preadmission screening team must sign the individual service plan. The preadmission screening team must give the person or the person's representative a copy of the individual service plan.

A. The preadmission screening team has determined that the person being screened is eligible for community services funded by an ACG under part 9505.2455, subpart 2.

B. Recommendation of an individual service plan that identifies:

(1) any treatment prescribed by the individual's attending physician as necessary and any follow–up treatment as necessary;

(2) the community services needed by the person;

(3) the available providers of the identified community services including ACG service providers under contract with or employed by the local agency and informal support networks such as family, friends, volunteers, and church groups;

(4) the needed frequency of the services;

(5) the initial date on which each service must begin;

(6) the funding sources for the community services;

(7) the estimated cost of skilled nursing services provided by public health nursing services;

(8) the total cost of the ACG services;

(9) an estimate of the total cost of the community services; and

(10) the name of the case manager assigned by the county of service.

C. The preadmission screening team allowed the person or the person's representative to choose among the available providers listed in the directory of services who are under contract with or employed by the county of service.

D. The preadmission screening team reviewed the individual service plan with the person or the person's representative at the time of the completion of the preadmission screening.

Subp. 5. **Sliding fee information.** The preadmission screening team must tell the person being screened who would be eligible to receive medical assistance within 180 days after admission to the nursing home about the amount of the sliding fee that the person is required to pay for alternative care grant services according to the sliding fee schedule established by the commissioner under Minnesota Statutes, section 256B.091, subdivision 8, if the person will be receiving ACG services under an individual service plan developed under subpart 4.

Subp. 6. **Assignment of case manager.** Upon completion of the individual service plan, the local agency of the county of service shall assign a case manager to implement the individual service plan prepared for an ACG client under subpart 4.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2435 RESCREENING.

Subpart 1. **Applicability.** The preadmission screening team must conduct a rescreening when the local agency receives either a written or oral request under subpart 2 suggesting that a recommendation resulting from a rescreening would differ from the recommendation given by the preadmission screening team at the last preadmission screening. Rescreenings must be conducted for all persons who meet the above criteria except ACG clients.

Subp. 2. **Request for rescreening.** The applicant, nursing home resident, or person's representative must submit a request to the local agency to be rescreened when the applicant or nursing home resident meets the criteria in subpart 1. The request may be oral or written and must state the date and location of the person's last preadmission screening and any changes in the person's health and social needs that have occurred since the last screening.

Subp. 3. **Rescreening procedure.** The rescreening must be conducted according to the procedures for preadmission screening in parts 9505.2390 to 9505.2450.

Subp. 4. **Reimbursement for rescreening.** Reimbursement to the local agency for rescreening must be the same as reimbursement of a preadmission screening under parts 9505.2440 and 9505.2445.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2440 PREADMISSION SCREENING RATE.

For rate years beginning on January 1, 1989, the commissioner shall annually establish the maximum statewide rate allowed for reimbursement of preadmission screening and the maximum reimbursement rate of a local agency for preadmission screening. The maximum statewide rate and the maximum reimbursement rate of a local agency shall not exceed the prior year's rate by more than the percentage change between the two previous Junes in the all urban consumer price index (CPI–U) for Minneapolis–Saint Paul new series index (1967=100) as published by the Bureau of Labor Statistics, United States Department of Labor. The CPI–U is incorporated by reference and is available from the Minitex interlibrary loan system. The CPI–U is subject to frequent change. By January 15 of each year, the commissioner must send a written notice of the maximum reimbursement rate to a local agency.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2445 REIMBURSEMENT FOR PREADMISSION SCREENING.

Subpart 1. **County of financial responsibility for preadmission screening of a recipient.** The county of financial responsibility for a recipient is as defined in Minnesota Statutes, chapter 256G.

Subp. 2. **Medical assistance reimbursement for preadmission screening of a recipient.** The medical assistance program must reimburse a local agency for the preadmission screening of a recipient if the local agency has complied with the time requirements of part 9505.2420. The local agency of the county of financial responsibility shall submit invoices for reimbursement of preadmission screening costs for a recipient to the department at the times and as required in part 9505.0450, subpart 2.

Subp. 3. **Reimbursement for preadmission screening of persons who are not recipients.** Reimbursement for the preadmission screening of persons who are not recipients must be made according to Minnesota Statutes, section 256B.091, subdivision 4.

Subp. 4. **Required local agency estimate of the cost and number of preadmission screenings of persons other than recipients.** Annually by February 15, a local agency must prepare and submit to the department an estimate for the following state fiscal year of the number and costs of preadmission screenings of persons who are not recipients and who will be applicants or nursing home residents for whom the county will provide preadmission screening.

Subp. 5. **Local agency's allocation of cost estimate to a nursing home.** Using the annual estimate of the number and costs of preadmission screenings required in subpart 4, a local agency must calculate the monthly amount to be paid by a nursing home to the local agency for preadmission screenings performed by the local agency for the following state fiscal year. The amount must be based on the nursing home's percentage of the number of licensed beds in nursing homes in the county of the local agency. The local agency must submit the amount to the nursing home by February 15.

Subp. 6. **Reconciliation of estimate required in subpart 4 with actual cost.** Annually by January 15, the department shall reconcile its estimated cost of a nursing home's number of preadmission screenings of persons who are not recipients as calculated under subpart 4 with the actual cost of preadmission screenings of these persons performed in the previous state fiscal year. The department shall notify the local agency of the amount of the overpayment or underpayment that the local agency must use in completing the calculation required under subpart 4.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2450 PENALTIES.

Subpart 1. **Penalty to nursing home for admission of an unscreened applicant.** A nursing home that admits an unscreened applicant who is subject to the preadmission screening requirement under part 9505.2400 or that fails to notify the preadmission screening team about an emergency admission as required under part 9505.2420, subpart 3, item B, is subject to the penalties in items A to C.

A. If the applicant is a recipient, the nursing home must not be reimbursed by medical assistance for the applicant's resident days that preceded the date of completion of the applicant's assessment by the preadmission screening team under part 9505.2425. Furthermore, the nursing home must not bill an unreimbursed resident day to the unscreened applicant who is a recipient.

B. If the applicant is not a recipient, the nursing home must not bill the applicant for the applicant's resident days that preceded the date of completion of the applicant's assessment by the preadmission screening team under part 9505.2420.

C. The nursing home must include an unreimbursed resident day in the nursing home's resident day total reported to the department for the purpose of rate calculation under parts 9549.0010 to 9549.0080.

Subp. 2. **Penalty to county of service for late screening.** A county of service required to act within the time requirements in part 9505.2420 that fails to act within the time requirements shall not receive reimbursement for the preadmission screening under part 9505.2445, subparts 2 and 3, from medical assistance in the case of a recipient or from the nursing home in the case of a person who is not a recipient. Under these circumstances, the county of service shall be solely responsible for the costs of the preadmission screening. Nevertheless, the county of service must complete the preadmission screening as required in parts 9505.2400 and 9505.2425.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2455 ALTERNATIVE CARE GRANTS.

Subpart 1. **Preadmission screening determination of eligibility.** The preadmission screening team must determine if the applicant or nursing home resident is eligible for an ACG under the criteria in subpart 2. If the person being screened is eligible for an ACG, the preadmission screening team must:

A. determine the county of financial responsibility according to subpart 3;

B. determine the county of service; and

C. determine the amount of the fee to be paid by the person if the person would be eligible to receive medical assistance within 180 days after admission to a nursing home. The amount of the sliding fee must be determined according to the sliding fee schedule established by the commissioner under Minnesota Statutes, section 256B.091, subdivision 8, and on forms provided by the commissioner.

Subp. 2. **Eligibility criteria.** A person is eligible for an ACG if the person meets the criteria in items A to H:

A. the person has been screened by the preadmission screening team;

B. the person is 65 years or older;

C. the person is a recipient or is eligible for medical assistance under parts 9505.0010 to 9505.0150 or would be eligible to receive medical assistance within 180 days after admission to a nursing home;

D. the person would require nursing home care if community services were not available;

E. the person is an applicant who chooses to remain in the community and use community services or a nursing home resident who chooses to leave the nursing home and receive community services;

F. the person requires community services that cannot be provided by services funded by sources other than alternative care grants;

G. the person has completed an application for community services; and

H. the cost of an ACG is within the monthly limitation specified in subpart 8.

Subp. 3. **Determination of county of financial responsibility for alternative care grants.** The preadmission screening team must determine the county of financial responsibility for an ACG client according to item A or B.

A. The county of financial responsibility for an ACG client who is a recipient is the county as defined in Minnesota Statutes, chapter 256G.

B. When ACG services begin, the county of financial responsibility for an ACG client who would be eligible to receive medical assistance within 180 days after admission to a nursing home is the county of financial responsibility as defined in Minnesota Statutes, chapter 256G for medical assistance recipients.

Subp. 4. **Use of alternative care grants.** ACG services may be reimbursed through an ACG if the person is eligible under subpart 2 and if the services are identified as needed in the ACG client's individual service plan and if the services are subject to the rates established in part 9505.2490. However, reimbursement for respite care services is limited to payment for 30 days of service in one state fiscal year.

Subp. 5. **Supplies and equipment.** If the ACG client is a recipient and the supplies and equipment are covered services under part 9505.0310, the cost of the supplies and equipment shall be paid as provided in the medical assistance program under parts 9505.0170 to 9505.0475 to the extent that reimbursement of the cost is not available from Medicare and a third–party payer as defined in part 9505.0015, subpart 46. A local agency shall use ACG money to buy or rent care related supplies and equipment for an ACG client as specified in items A to C.

A. If the supplies and equipment are not covered services under part 9505.0310 or the ACG client is not a recipient and the cost of the supplies and equipment for the ACG client is not more than $100 per month, the local agency shall authorize the use of ACG funds.

B. If the supplies and equipment are not covered services under part 9505.0315 or the ACG client is not a recipient and the cost of the supplies and equipment exceeds $100 per month, the local agency must obtain prior authorization from the department to use ACG funds to pay the cost of the supplies and equipment. For purposes of this subpart, "prior authorization" means written approval and authorization given by the department to the local agency before the purchase or rental of the supply or equipment.

C. The department shall have the right to determine whether the supplies and equipment are necessary to enable the client to remain in the community. If the department determines that the supplies and equipment are necessary to enable the ACG client to remain in the community and if the cost of the supplies and equipment together with all other ACG services and skilled nursing services provided by public health nursing services is less than the limitation in subpart 8, the department shall authorize the use of the ACG funds to pay the cost.

Subp. 6. **Supervision costs.** The cost of supervising a home health aide or personal care assistant must be included in the rate for home health aide or personal care services, unless payment for the cost of supervision is included in the rate for skilled nursing service. If the cost of supervising a home health aide or personal care assistant is included in the rate for skilled nursing service, the cost must not be included in the payment for a home health aide or personal care assistant. The cost of supervising an alternative care grant service other than a personal care service or a health aide service must be included in the rate for the service.

Subp. 7. **Unallowable costs.** Alternative care grants must not be used:

A. to establish community services for which funding sources are available through other programs;

B. to pay for community services that can be reimbursed through other funding sources including Medicare and third–party payers as defined in part 9505.0015, subpart 46;

C. to pay for room and board costs except for respite care provided outside of the ACG client's residence; or

D. to pay providers that are not under contract with the local agency under Minnesota Statutes, section 256B.091, subdivision 8.

Subp. 8. **Costs included within the monthly limitation of an ACG to an ACG client.** In a calendar month, the total cost of an ACG to an ACG client must not exceed the total state-

wide monthly average payment of the resident class to which the ACG client would be assigned under parts 9549.0050 to 9549.0059, calculated from the payments made for that resident class in the previous fiscal year. The following costs must be included in determining the total costs of an ACG:

A. cost of all ACG services;

B. cost of skilled nursing services provided by public health nursing services and reimbursable under parts 9505.0170 to 9505.0475; and

C. cost of supplies and equipment funded by an ACG.

Subp. 9. **Criteria for selection as an ACG provider.** A provider who provides ACG services must meet the criteria in items A and B.

A. The provider must be employed by or have contracted with the local agency to provide ACG services.

B. The provider must meet all licensure requirements and professional standards established in Minnesota Statutes, Minnesota Rules, and the Code of Federal Regulations that apply to the services provided.

Subp. 10. **Contract for ACG services.** If the local agency contracts with a provider under subpart 9, the contract must:

A. set beginning and ending dates for the term of the contract;

B. specify the duties and responsibilities of the local agency and the provider;

C. require the provider to comply with parts 9505.2390 to 9505.2500;

D. specify the amount that the local agency must reimburse the provider for the services;

E. specify reports and record retention required of the provider by the local agency;

F. specify the conditions under which the local agency shall terminate the provider's contract; and

G. specify documentation of an individual abuse prevention plan that complies with parts 9555.8000 to 9555.8500 if such a plan is required of the provider by Minnesota Statutes, section 626.557.

Subp. 11. **Reassessment of ACG clients.** A face–to–face reassessment of an ACG client must be conducted by the case manager at least once every six months after ACG services have begun. The case manager must also reassess an ACG client when the case manager determines that changes in the health and social needs or the financial status of the ACG client require revisions in the individual service plan. When an ACG client leaves the county of service and establishes residence in another Minnesota county, the case manager responsible for implementing the ACG client's individual service plan must notify the local agency of the other county about the client's change in residence and request the other county to assign a case manager and conduct a reassessment.

Subp. 12. **Record of reassessment.** At the time of an ACG client's reassessment, the case manager must complete an assessment form and give the ACG client an information form or forms supplied by the commissioner containing the information required in part 9505.2425, subpart 3, items C to E. The case manager must document in the ACG client's case record that the client received the required information. The ACG client's case record of reassessment shall contain at least the information in items A to G:

A. the completed assessment form;

B. the reason for the reassessment;

C. a redetermination of financial eligibility for the ACG client;

D. the names and relationship to the client of the persons consulted during the reassessment;

E. any revisions of the individual service plan that will occur in type, frequency, and cost of ACG services resulting from the reassessment;

F. a completed quality assurance and review (QA&R) form, as required by part 9549.0059, with an estimate of the client's resident class; and

G. a recomputed sliding fee for the client who would be eligible to receive medical assistance within 180 days after admission to a nursing home.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2458 CASE MANAGER ACTIONS TO ASSURE SAFETY AND HEALTH OF ACG CLIENT WHO IS A VULNERABLE ADULT.

A case manager who has reason to believe an ACG client who is a vulnerable adult is or has been subject to abuse or neglect as defined in Minnesota Statutes, section 626.557, subdivision 2, that occurs at the client's residence or the place where the client receives the ACG service shall immediately comply with the reporting and other actions required under Minnesota Statutes, section 626.557, and shall determine how to assure the client's health and safety during the local agency's investigation. The case manager shall determine whether to withdraw the services, work out another living arrangement for the client, or arrange for the services of another ACG provider. When the case manager receives the findings of the local agency's investigation, the case manager shall amend the ACG client's individual service plan as needed to assure the client's health and safety.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2460 LOCAL AGENCY SELECTION OF ACG PROVIDERS.

Subpart 1. **Public meeting to inform providers.** The local agency must hold an annual public meeting with possible providers of ACG services to inform providers about the criteria for provider selection as listed in subpart 4 and the date by which requests to be an ACG provider must be submitted to the local agency. The local agency may hold the annual public meeting at a time convenient to its schedule for completing service contracts to be included in its annual plan. The local agency must document that the notice required in subpart 2 was given and that the public meeting was held.

Subp. 2. **Notice of annual public meeting.** The local agency must place a notice of the public meeting required under subpart 1 in the newspaper that is the official newspaper designated by the county board of commissioners of the local agency under Minnesota Statutes, section 279.08. The notice must appear at least 14 days before the public meeting and must state the date, time, and place of the meeting, the type of services for which a need is anticipated, the criteria in subpart 3 for selection as an ACG provider, the date by which the local agency will complete its selection of ACG providers, and the name, telephone number, and address of the local agency's contact person who can provide information about the criteria for selection and contract terms.

Subp. 3. **Selection criteria.** The local agency must select providers for ACG contracts as required in Minnesota Statutes, section 256B.091, subdivision 8, using the criteria in items A to G and other criteria established by the local agency that are consistent with items A to G:

A. the need for the particular service offered by the provider;

B. the population to be served including the number of ACG clients, the length of time service will be provided, and the medical condition of the ACG clients;

C. the geographic area to be served;

D. the quality assurance methods to be used by the provider including compliance with required licensures, certifications, or standards and supervision of employees as required by parts 9505.2390 to 9505.2500;

E. the rate for each service or unit of service exclusive of county administrative costs;

F. evaluation of services previously or currently provided by the provider; and

G. the provider's previous compliance with contract provisions and future ability to comply with contract provisions including billing requirements, and terms related to contract cancellation and indemnification. The local agency must evaluate the ACG services that it provides to ACG clients using the criteria in this subpart.

Subp. 4. **Written record of reason for not selecting a provider.** A local agency must keep a written record of the reason a provider who requests a contract to provide ACG services was not selected and must notify the provider of the reasons.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2465 STANDARDS FOR PERSONAL CARE SERVICES.

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

A. "Personal care provider" means a home health agency that meets the requirements of subpart 5 and is under contract to the local agency to provide personal care assistants or a local agency licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47, or registered under Minnesota Statutes, section 144A.49.

B. "Personal care service" means a service listed in subpart 3 that is ordered by a physician and provided by a personal care assistant to an ACG client to maintain the ACG client in his or her residence.

Subp. 2. **Training requirements.** Personal care services must be provided by a personal care assistant who has successfully completed one of the training requirements in items A to E:

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

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

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

D. a training program that provides the personal care assistant with skills required to perform the services specified in subpart 3; or

E. determination by the supervising registered nurse that the personal care assistant has, through training or experience, the skills required to perform the duties specified in subpart 3.

Subp. 3. **Personal care services.** The duties specified in items A to N are components of personal care services:

A. bowel and bladder care;

B. skin care done to maintain the health of the skin, including prophylactic routine and palliative measures such as exposure to air, use of nondurable medical equipment, application of lotions, powders, ointments, and treatments such as heat lamp and foot soaks;

C. range of motion exercises;

D. respiratory assistance;

E. transfers;

F. bathing, grooming, and hairwashing necessary for personal hygiene;

G. turning and positioning;

H. assistance with furnishing medication that is ordinarily self administered;

I. application and maintenance of prosthetics and orthotics;

J. cleaning equipment;

K. dressing or undressing;

L. assistance with food, nutrition, and diet activities;

M. accompanying an ACG client to obtain medical diagnosis or treatment and to attend other activities such as church if the personal care assistant is needed to provide personal care services while the recipient is absent from his or her residence; and

N. performing other services essential to the effective performance of the duties in items A to M.

Subp. 4. **Employment of personal care assistants.** A personal care assistant who provides personal care services under the ACG program is not an employee of the ACG client

but must be employed by or under contract with a personal care provider. A personal care assistant employed by a personal care provider must meet the training requirements in subpart 2. The personal care provider shall terminate the personal care assistant's employment or assignment to an ACG client if the supervising registered nurse determines that the personal care assistant is not performing satisfactorily.

Subp. 5. **Personal care provider; eligibility.** Except as provided in subpart 11, a local agency that is not licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47 or registered under Minnesota Statutes, section 144A.49, and that wants to provide personal care services under the ACG program must contract with a personal care provider to provide the personal care services. To be eligible to contract with the local agency as a personal care provider, the provider must meet the criteria in items A to K. The local agency must assure the provider's compliance with the criteria in items A to K:

A. be licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47, or registered under Minnesota Statutes, section 144A.49;

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

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

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

E. demonstrate a knowledge of, sensitivity to, and experience with the special needs, including communication needs, and the condition of the ACG client;

F. provide a quality assurance mechanism;

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

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

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

J. demonstrate a system of personnel management; and

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

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

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

B. supervise the personal care services as in subpart 9;

C. if the provider is not the local agency, submit a bill to the local agency for personal care services provided by the personal care assistant;

D. establish a grievance mechanism to resolve consumer complaints about personal care services;

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

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

G. comply with applicable rules and statutes; and

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

Subp. 7. **Employment prohibition.** A local agency that provides ACG services to an ACG client whether the services are provided by the local agency as a personal care provider or under contract with a personal care provider must prohibit the employment of a person to provide personal care services for an ACG client if the personal care assistant:

A. refuses to provide full disclosure of criminal history records as specified in subpart 8;

B. has been convicted of a crime that directly relates to the occupation of providing personal care services to a qualified recipient;

C. has jeopardized the health or welfare of a vulnerable adult through physical abuse, sexual abuse, or neglect as defined in Minnesota Statutes, section 626.557; or

D. is misusing or is dependent on mood altering chemicals including alcohol to the extent that the personal care provider knows or has reason to believe that the use of chemicals has a negative effect on the ability of the personal care assistant to provide personal care services or the use of chemicals is apparent during the hours the personal care assistant is providing personal care services.

Subp. 8. **Preemployment check of criminal history.** Before employing a person as a personal care assistant for an ACG client, the personal care provider shall require from the applicant for employment full disclosure of conviction and criminal history records pertaining to any crime related to the provision of health services under the medical assistance program or to the occupation of a personal care assistant.

Subp. 9. **Supervision of personal care assistant.** A personal care assistant must be under the supervision of a registered nurse. The supervising registered nurse shall not be a member of the family of the ACG client who is receiving personal care service from the personal care assistant under the registered nurse's supervision. The supervising registered nurse must:

A. ensure that the personal care assistant is capable of providing the personal care services required in the ACG client's individual treatment plan required by part 9505.2475 through direct observation of the assistant's performance or through consultation with the ACG client and the ACG client's primary caregiver when possible;

B. ensure that the personal care assistant is knowledgeable about the individual treatment plan before the personal care assistant performs the personal care services;

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

D. evaluate the personal care services of an ACG client through direct observation of the personal care assistant's work or through consultation with the ACG client;

E. review the individual treatment plan with the ACG client and the personal care assistant at least once every 120 days and revise the individual treatment plan as necessary;

F. ensure that the personal care assistant and ACG client are knowledgeable about any change in the individual treatment plan; and

G. review all entries made in the ACG client's health care record showing the services provided and the time spent by the personal care assistant.

Subp. 10. **Evaluation of services.** The supervising registered nurse shall evaluate the personal care assistant's work under the schedule in items A to C.

The supervising registered nurse must record in writing the results of the evaluation and action taken to correct any deficiencies in the work of the personal care assistant.

A. Within 14 days after the placement of a personal care assistant with the ACG client.

B. At least once every 30 days during the first 90 days after the ACG client first begins to receive personal care services under the individual service plan developed by the screening team.

C. At least once every 120 days following the period of evaluations in item B.

Subp. 11. **Employment and reimbursement of a relative as a personal care assistant.** A relative of an ACG client, with the exception of the ACG client's spouse, shall be reimbursed for providing personal care services to an ACG client only if the relative and the local agency meet the requirements in items A to D.

A. The relative must be employed by or under contract with the local agency or a personal care provider. A local agency employing a relative under this subpart does not have to be licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47.

B. The relative would suffer financial hardship as a result of providing the ACG client's personal care services or a personal care assistant who is not a relative is not available to perform the ACG client's personal care services. For purposes of this subpart, financial

hardship refers to a situation in which a relative incurs a substantial reduction in income because he or she resigns from a full–time job, goes from a full–time to a part–time job paying considerably less compensation, takes a leave of absence without pay from a full–time job to care for an ACG client, or incurs substantial expenses in making arrangements necessary to enable the relative to care for an ACG client.

C. The relative and the local agency must meet the requirements of subparts 2, 3, and 7 to 10.

D. The local agency has obtained the department's prior approval.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258; L 1990 c 375 s 3*

9505.2470 STANDARDS FOR HOME HEALTH AIDE SERVICES.

Subpart 1. **Employment of home health aide.** A home health aide who provides home health aide services under the ACG program to an ACG client must be an employee of a provider of home health aide services. The home health aide must be under the supervision of a registered nurse. Registered nurses and practical nurses licensed under Minnesota Statutes, sections 148.29 to 148.299 shall not be employed as home health aides under the ACG program.

Subp. 2. **Eligible providers.** To be eligible as a provider of home health aide services under the ACG program, a home health agency must be licensed under Minnesota Statutes, sections 144A.43 to 144A.46, and certified to participate under titles XVIII and XIX of the Social Security Act.

Subp. 3. **Approval and supervision of home health aide services.** A home health aide providing home health aide services in the ACG program must be approved by the supervising registered nurse to perform the medically oriented tasks written in the ACG client's individual treatment plan. The supervising registered nurse must be an employee of a home health agency that is providing the home health aide services.

Subp. 4. **Record of home health aide services.** A home health agency providing home health aide services to an ACG client must keep a record documenting the provision of home health aide services in the client's individual treatment plan. The documentation shall include the date and nature of the services provided and the names of the home health aide and the supervising registered nurse.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2473 STANDARDS FOR HOMEMAKER SERVICES.

Subpart 1. **Qualified homemakers.** The local agency shall assure that each ACG client receiving homemaker services is served by a homemaker qualified under part 9565.1200, subpart 2. A person who is providing a homemaker service under the ACG program to an ACG client who is the person's relative must meet the standards in part 9565.1200, subpart 2.

Subp. 2. **Contracting for homemaker services and supervision of a homemaker.** The local agency may directly provide or contract for homemaker services that are part of the ACG client's individual service plan. If the local agency provides homemaker services directly, the local agency must also provide supervision of the homemaker's activities. If the local agency contracts with a provider for homemaker services, the provider must meet the requirements of Minnesota Statutes, sections 144A.43 to 144A.46 or 144A.49.

Subp. 3. **Payment limitations; homemaker.** ACG payments shall be made only for the homemaker tasks specified in part 9505.2395, subpart 23, that are required by and indicated in the ACG client's individual service plan.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2475 ESTABLISHMENT OF INDIVIDUAL TREATMENT PLAN.

Subpart 1. **Requirement.** An individual treatment plan must be developed for an ACG client who receives home health aide services or personal care services. The ACG client's

physician and the supervising registered nurse, together with the personal care assistant or the home health aide, the ACG client and the ACG client's representative, if any, must develop the individual treatment plan. The ACG client's physician and the supervising registered nurse must review the plan every 60 days and revise the plan if a revision is necessary to help the ACG client meet his or her needs. The supervising registered nurse must give a copy of the client's individual treatment plan to the ACG client's case manager and the home health agency that provides the home health or personal care services.

Subp. 2. **Contents of ACG client's individual treatment plan.** The ACG client's individual treatment plan must meet the requirements of Code of Federal Regulations, title 42, section 405.1223.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2480 ALLOCATION OF STATE ACG MONEY.

Subpart 1. **Formula for allocation of state ACG money.** Annually before July 1, the commissioner must allocate state money available for alternative care grants to each local agency.The allocation must include the state share of money for services provided to recipients under the waiver and the state share of money for services to persons who would be eligible to receive medical assistance within 180 days after nursing home admission. The allocation must be made according to Minnesota Statutes, section 256B.091, subdivision 8. State funds allocated by the commissioner to a local agency for ACG services provided under the waiver shall not be used for any purpose other than services under the waiver.

Subp. 2. **Review of allocation; reallocation of state ACG money.** The commissioner must review the local agencies' projected and expended state ACG money on a quarterly basis. The commissioner must reduce the allocation of state ACG money to a local agency if the commissioner determines that the local agency will not use the full state allocation during the state fiscal year. The commissioner must reallocate the unused portion of the local agency's allocation to a local agency that has or wants to have more ACG clients than were projected to be served in its biennial plan.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2485 ALLOCATION OF NUMBER OF ACG CLIENTS TO BE SERVED UNDER THE WAIVER.

Subpart 1. **Local agency allocation of ACG clients under the waiver.** At least annually, the commissioner must allocate the number of ACG clients who are recipients and for whom each local agency is financially responsible under the waiver. The commissioner must determine from the medical assistance eligibility data provided as of March 1 by the counties to the department each local agency's allocation according to the county's percentage of the statewide total number of recipients who are age 65 or older.

Subp. 2. **Review of allocation; reallocation of number of ACG clients under the waiver.** The commissioner shall review the projected and actual number of ACG clients served under the waiver by all local agencies on a quarterly basis. The commissioner may reduce the number of ACG clients allocated to a local agency if the commissioner determines that the local agency will serve fewer than its allocated number of ACG clients during the allocation period. The commissioner may reallocate the unused portion of the local agency's initial allocation to another local agency.

Subp. 3. **Notice to local agency.** The commissioner shall notify a local agency annually before May 15 of the number of recipients to be served as ACG clients under the waiver under subpart 1 and shall notify a local agency at least 15 days before the effective date of a change in the number of ACG clients allocated to the local agency under subpart 2.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2486 LOCAL AGENCY ESTIMATION OF NUMBER OF PERSONS OTHER THAN RECIPIENTS TO BE SERVED AS ACG CLIENTS.

A local agency must estimate the number of persons other than recipients to be served as ACG clients. The estimate shall depend on the extent that ACG funds allocated to the local

agency as required by part 9505.2480 are available. The local agency must report the estimate in the biennial plan and revisions to the biennial plan required in part 9505.2495, subpart 2.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2490 RATES FOR ACG SERVICES.

Subpart 1. **Statewide maximum ACG service rate.** For years beginning on July 1, 1989, the commissioner must annually set a statewide maximum rate allowed for payment of providing an ACG service. The statewide maximum rate must not exceed the prior fiscal year's rate by more than the percentage change between the two previous Januarys indicated by the all urban consumer price index (CPI–U) for Minneapolis–Saint Paul new series index (1967=100), as published by the Bureau of Labor Statistics, United States Department of Labor. The CPI–U is incorporated by reference and is available from the Minitex interlibrary loan system. The CPI–U is subject to frequent change.

Subp. 2. **Local agency maximum ACG service rate set by commissioner; general.** The commissioner shall annually set the maximum rate that is available to a local agency for reimbursing an ACG provider for an ACG service. For years beginning on July 1, 1989, the commissioner shall authorize an increase in the ACG rate available to a local agency for reimbursing an ACG provider equal to the percentage change between the two previous Januarys indicated by the all urban consumer price index (CPI–U) for Minneapolis–Saint Paul new series index (1967=100), as published by the Bureau of Labor Statistics, United States Department of Labor.

Subp. 3. **Local agency maximum ACG service rate set by commissioner; new ACG service.** A local agency that wants to contract for an ACG service that has not been provided before August 8, 1988, shall propose a maximum rate to the commissioner that does not exceed the statewide maximum ACG service rate established by the commissioner under subpart 1.

Subp. 4. **Notice to local agency.** Annually by May 15, the commissioner shall notify each local agency of the statewide maximum rate allowed for payment of providing an ACG service under subpart 1. Additionally, the commissioner shall notify the local agency in writing of the percentage increase allowed under subpart 2.

Subp. 5. **Local agency request to exceed county's maximum rate.** Notwithstanding the limitation on the local agency's maximum rate for an ACG service in subpart 2, a local agency that wants to increase an ACG service rate more than the percentage authorized by the commissioner under subpart 2 may submit a request for the increase to the commissioner. The local agency must justify the need for the greater increase by submitting evidence that documents an increase in costs, such as wages established under a union contract, taxes, utility costs, or transportation charges, that exceeds the percentage change or that shows that the higher rate is necessary to obtain the desired service within the local agency's local trade area. For purposes of this subpart, "local trade area" has the meaning given in part 9505.0175, subpart 22.

Subp. 6. **Local agency ACG service rate subject to audit and approval.** A local agency ACG service rate and a request to exceed the local agency's maximum ACG service rate are subject to audit and approval by the commissioner.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2495 LOCAL AGENCY REPORTS AND RECORDS.

Subpart 1. **Preadmission screening documents.** The local agency must complete and submit to the commissioner a preadmission screening document that summarizes the assessment and recommendations of the preadmission screening team on an applicant, nursing home resident, or ACG client for whom the local agency has completed a preadmission screening or a reassessment. The document must be submitted by the tenth of the month following the month in which a preadmission screening or reassessment was completed.

Subp. 2. **Local agency biennial plans.** The local agency must submit a biennial plan for preadmission screening and ACGs on forms prepared by the commissioner. The local

agency must submit the biennial plan to the commissioner by July 1 of odd numbered years in order for the local agency to receive preadmission screening funds or ACG funds during the next two state fiscal years. The local agency must submit revisions to the biennial plan to the commissioner for approval before implementing the revisions. The biennial plan must include items A to F:

A. name and address of the local agency;

B. names and titles of the preadmission screening team;

C. names of ACG service providers;

D. identification of the types of ACG services the local agency will provide and the rates for the services;

E. an ACG budget and estimates of the number of recipients and other persons to be served as ACG clients for the first year of the biennium and an estimated budget and estimated number of clients to be served for the second year of the biennium. No later than July 1 of the second year of the biennium, each local agency must submit the actual budget and revised estimate of the number of clients to be served proposed for the second year of the biennium; and

F. assurances of compliance with Minnesota Statutes, section 256B.091, and parts 9505.2390 to 9505.2500.

Subp. 3. **Commissioner approval of local agency biennial plan.** The commissioner must approve or reject by August 15 a biennial plan submitted by the local agency as required in subpart 2, item E.

Subp. 4. **ACG provider records.** The local agency and each ACG provider under contract with the local agency must maintain complete program and fiscal records and supporting documentation identifying the ACG clients served, the services provided, and the costs incurred. The records must be identified and maintained separate from other provider records. The local agency's and provider's records including the local agency's contract with the ACG provider are subject to the maintenance schedule, audit availability requirements, and other provisions in parts 9505.2160 to 9505.2245.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2496 CRITERION FOR DELAY IN SENDING REQUIRED NOTICES.

If information that the commissioner needs to prepare and send the notices required under parts 9505.2390 to 9505.2500 is not provided in time for the commissioner to meet the time specified in these parts, the required notices shall be sent as soon as possible after the commissioner receives the needed information.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2500 APPEALS OF SCREENINGS, RESCREENINGS, AND REASSESSMENTS.

Subpart 1. **Information about the right to appeal.** A preadmission screening team must provide a person being screened under part 9505.2400, rescreened under part 9505.2435, or reassessed under part 9505.2455, subpart 11, or the person's representative, information about the person's right to appeal the recommendation of the screening team. The information must be in writing and must be given to the person or the person's representative during the preadmission screening. The information must state the grounds for an appealable action and that ACG services will not be reduced, suspended, or terminated if the appeal is filed before the date specified in the information unless the person requests in writing not to receive continued ACG services while the appeal is pending.

Subp. 2. **Appealable actions.** A person being screened, rescreened, or reassessed may appeal if:

A. the recommendation of the preadmission screening team is to deny ACG services;

B. the preadmission screening team fails to determine with reasonable promptness whether the person is eligible for ACG services; or

C. the recommendation of the case manager based on a reassessment under part 9505.2455, subpart 11, is to reduce, suspend, or terminate ACG services.

Subp. 3. **Denial, reduction, suspension, or termination because of insufficient ACG funds or openings.** A denial, reduction, suspension, or termination of ACG services is not an appealable action if the county of financial responsibility has depleted the amount of money allocated under part 9505.2480 or assigned all the openings to serve ACG clients allocated under parts 9505.2485 and 9505.2486 or if the client's case manager withdraws ACG services as provided under part 9505.2458. Additionally, termination of an ACG service being provided to an ACG client under the waiver is not appealable if the termination results from termination of the waiver.

Subp. 4. **Submission of appeals.** The person being screened or the representative of the person being screened who wants to appeal the screening team's recommendation must submit the appeal in writing to the local agency of the county of service or to the department within 30 days after receiving written notice of the appealable action, or within 90 days of the written notice if a justified reason for delay can be shown.

Subp. 5. **Appeal of action.** An appeal of issues meeting the criteria under subparts 1, 2, and 4 shall be heard and decided in accordance with Minnesota Statutes, section 256.045.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

COMMUNITY ALTERNATIVES FOR DISABLED INDIVIDUALS PROGRAM

9505.3010 SCOPE AND EFFECT.

Subpart 1. **Scope.** Parts 9505.3010 to 9505.3140 establish standards and procedures for the community alternatives for disabled individuals program. The community alternatives for disabled individuals program allows Medicaid to pay for approved community–based services provided to eligible persons. The community–based services allow persons who would otherwise reside in a nursing home to remain at home or return to the community. Those persons must meet the requirements of part 9505.3035.

Parts 9505.3010 to 9505.3140 must be read in conjunction with section 1915(c) of the Social Security Act; Minnesota Statutes, sections 256B.04, subdivision 2; 256B.05; 256B.091, subdivisions 1 to 8; 256B.49; 256B.491; Code of Federal Regulations, title 42, sections 440.180 and 441.300 to 441.310, amended through October 1, 1987; and parts 9505.2390 to 9505.2500. Parts 9505.3010 to 9505.3140 must be read in conjunction with the requirements of the waiver obtained by the state from the United States Department of Health and Human Services.

Subp. 2. **Effect.** Parts 9505.3010 to 9505.3140 are effective only as long as the waiver from the United States Department of Health and Human Services remains in effect in Minnesota.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3015 DEFINITIONS.

Subpart 1. **Applicability.** The definitions in this part apply to parts 9505.3010 to 9505.3140.

Subp. 2. **Adaptations.** "Adaptations" means minor physical modifications to the home, adaptive equipment, and minor modifications to vehicles as specified in part 9505.3075.

Subp. 3. **Adult day care services.** "Adult day care services" means services provided to recipients by adult day care centers licensed under parts 9555.9600 to 9555.9730 and adult day care family homes established under Minnesota Statutes, sections 245A.01 to 245A.17.

Subp. 4. **Applicant.** "Applicant" means a person under age 65 or the representative of a person under age 65 who applies to participate in the community alternatives for disabled individuals program rather than enter a nursing home. Applicant also means a person or the representative of a person who has been admitted to a nursing home as a resident, but who has requested an assessment under part 9505.3025 to participate in the CADI program.

Subp. 5. **Assessment form.** "Assessment form" means the form supplied by the commissioner that is used to record the information required under parts 9505.2425, subpart 1, and 9505.3025.

Subp. 6. **Care plan or individual plan of care.** "Care plan" or "individual plan of care" means the written plan of a combination of services designed to meet the health and community–living needs of an applicant according to part 9505.3030.

Subp. 7. **Case management services.** "Case management services" means the services as specified in part 9505.3070 that identify, assist in gaining access to, authorize, and coordinate services for a recipient; monitor the delivery of services to the recipient; adjust services to the needs of the recipient; and advocate for the rights of the recipient to assure the health and safety of the recipient.

Subp. 8. **Case manager.** "Case manager" means a social worker employed by or under contract with the local agency, or a registered nurse who is employed by the local public health department or under contract with the local agency to provide case management. Local agency in this subpart means the local agency in the county of service.

Subp. 9. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or the commissioner's authorized representative.

Subp. 10. **Community alternatives for disabled individuals or CADI.** "Community alternatives for disabled individuals" or "CADI" means certain community–based services further described in parts 9505.3070 to 9505.3110 provided under a waiver to physically disabled individuals under the age of 65 who require the level of care provided in a nursing home. CADI services allow the persons to remain in their homes.

Subp. 11. **County of financial responsibility.** "County of financial responsibility" has the meaning given it in Minnesota Statutes, section 256G.02, subdivision 4.

Subp. 12. **County of service.** "County of service" means the county in which the applicant or recipient resides.

Subp. 13. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 14. **Directory of services.** "Directory of services" means the list of home and community–based services specified in part 9505.2395, subpart 17.

Subp. 15. **Extended home health services.** "Extended home health services" means the home health services specified in part 9505.3085.

Subp. 16. **Extended personal care services.** "Extended personal care services" means the personal care services specified in part 9505.3090.

Subp. 17. **Family.** "Family" means the persons who live with or provide informal care to a disabled individual. Family may include a spouse, children, friends, relatives, foster family, or in–laws.

Subp. 18. **Family support services; counseling and training.** "Family support services; counseling and training" means the services specified in part 9505.3095.

Subp. 19. **Formal caregivers.** "Formal caregivers" means persons or entities providing CADI services who are employed by or under contract with a local agency, or other agency or organization, public or private. Formal caregiver does not include case manager.

Subp. 20. **Home.** "Home" means the recipient's place of residence other than a nursing home. It includes a home owned or rented by the recipient, or a member of the recipient's family or foster family.

Subp. 21. **Home and community–based services.** "Home and community–based services" refers to services that provide adaptations and adult day care, case management, extended home health, extended personal care, family support, homemaker, independent living skills, respite care services, and medical supplies and equipment to a recipient through CADI.

Subp. 22. **Homemaker services.** "Homemaker services" means the services specified in part 9505.3100.

Subp. 23. **Independent living skills services.** "Independent living skills services" means supervision, training, or assistance to a recipient in self care, communication skills, socialization, sensory or motor development, reduction or elimination of inappropriate or

maladaptive behavior, community living, and mobility that is provided by individuals or agencies qualified to provide independent living skills services.

Subp. 24. **Informal caregivers.** "Informal caregivers" means family, friends, neighbors, and others who provide services to and assist recipients without reimbursement for the services.

Subp. 25. **Lead agency.** "Lead agency" means the social service or public health agency approved by the county board to administer the CADI program.

Subp. 26. **Local agency.** "Local agency" means the county or multicounty agency authorized under Minnesota Statutes, section 256B.05, to administer the medical assistance program.

Subp. 27. **Medical assistance.** "Medical assistance" means the program including the CADI program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 28. **Mental illness.** "Mental illness" means, in the case of an adult, an illness as defined in Minnesota Statutes, section 245.462, subdivision 20, or, in the case of a child, an emotional disturbance as defined in Minnesota Statutes, section 245.4871, subpart 15.

Subp. 29. **Nursing home.** "Nursing home" means a facility, including a boarding care facility, licensed under Minnesota Statutes, chapter 144A, that is certified to participate in the medical assistance program.

Subp. 30. **Nursing home resident.** "Nursing home resident" means a person who lives, and expects to continue to live, in a nursing home for more than 30 days. For purposes of parts 9505.3010 to 9505.3140, nursing home resident does not include a person who is in a nursing home for respite care.

Subp. 31. **Person with mental retardation or a related condition.** "Person with mental retardation or a related condition" means a person as defined in part 9525.0015, subpart 20.

Subp. 32. **Personal care assistant.** "Personal care assistant" means a person who provides extended personal care services and meets the standards of part 9505.0335 or 9505.3090.

Subp. 33. **Physician.** "Physician" means a person who is authorized to practice medicine under Minnesota Statutes, chapter 147.

Subp. 34. **Preadmission screening or screening.** "Preadmission screening" or "screening" means the activities established under Minnesota Statutes, section 256B.091, subdivisions 1 to 4, and specified in part 9505.3025.

Subp. 35. **Preadmission screening team or team.** "Preadmission screening team" or "team" means the team defined in part 9505.2395, subpart 39, that is required under part 9505.3025 to assess the health and social needs of an applicant for CADI services.

Subp. 36. **Primary caregiver.** "Primary caregiver" has the meaning given it in part 9505.2395, subpart 40. The primary caregiver is designated by the recipient as his or her primary caregiver. Primary caregiver additionally means an informal caregiver of a recipient.

Subp. 37. **Public health nurse.** "Public health nurse" means a registered nurse who is qualified as a public health nurse under the Minnesota nurse practice act and employed by a public health nursing service as defined in subpart 38.

Subp. 38. **Public health nursing service.** "Public health nursing service" means the nursing program provided by a board of health under Minnesota Statutes, section 145.10, subdivision 1.

Subp. 39. **Reassessment.** "Reassessment" means the reevaluation of a CADI recipient's health and community–living needs under part 9505.3060.

Subp. 40. **Recipient.** "Recipient" means a person determined to be eligible for CADI services according to part 9505.3035, who chooses to receive the CADI services identified in the person's care plan, and whose services have been initiated.

Subp. 41. **Registered nurse.** "Registered nurse" means a person licensed under Minnesota Statutes, section 148.211.

Subp. 42. **Representative.** "Representative" means a person appointed by the court as a guardian or conservator under Minnesota Statutes, sections 252A.01 to 252A.21 or 525.539

to 525.6198; a spouse; a parent of a child under age 18 unless the parent's parental rights have been terminated; a person designated by a power of attorney or a durable power of attorney; or a person authorized by the applicant or recipient under part 9505.0015, subpart 8.

Subp. 43. **Resident class.** "Resident class" means the case mix classification assigned to a person as required under parts 9549.0058, subpart 2, and 9549.0059.

Subp. 44. **Respite care services.** "Respite care services" means short-term supervision, assistance, and care provided to a recipient, due to the temporary absence or need for relief of the primary caregiver.

Subp. 45. **Room and board costs.** "Room and board costs" means costs of providing food and shelter to a recipient including the identifiable direct costs of:

A. private and common living space;

B. normal and special diet food preparation and service;

C. linen, bedding, laundering, and laundry supplies;

D. housekeeping including cleaning and lavatory supplies;

E. maintenance and operation of buildings and grounds, including fuel, electricity, water, supplies, and parts and tools to repair and maintain equipment and facilities; and

F. salaries and other costs related to items A to E.

Subp. 46. **Skilled nursing service.** "Skilled nursing service" means the term defined in Code of Federal Regulations, title 42, section 405.1224.

Subp. 47. **Slot.** "Slot" means an opening available for services to a recipient under the waiver.

Subp. 48. **Social worker.** "Social worker" means a person who has met the minimum qualifications of a social worker under the Minnesota Merit System or a county civil service system in Minnesota.

Subp. 49. **State medical review team.** "State medical review team" means a team consisting of physicians and social workers who are under contract with or employed by the department to review a medical and social history to determine whether a person is disabled under the regulations of the Social Security Administration.

Subp. 50. **Vehicle.** "Vehicle" means a vehicle owned by the recipient or a member of the recipient's family or foster family that is used to transport a recipient with sensory or mobility defects.

Subp. 51. **Waiver.** "Waiver" means the document approved by the United States Department of Health and Human Services which allows the state to pay for home and community-based services authorized under Code of Federal Regulations, title 42, part 441, subpart G. The term includes all amendments to the waiver including any amendments made after May 29, 1990, as approved by the United States Department of Health and Human Services.

Subp. 52. **Waiver year.** "Waiver year" means October 1 to the following September 30.

Subp. 53. **Working day.** "Working day" has the meaning given it in part 9505.2395, subpart 56.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3020 PREADMISSION SCREENING OF CADI APPLICANTS.

Preadmission screening is required for all applicants for home and community-based services under CADI. The screening must incorporate the requirements of the 1987 Omnibus Budget Reconciliation Act, Public Law Number 100-203, about appropriate nursing home placement for persons with mental illness and for persons with mental retardation or related conditions.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3025 DUTIES OF PREADMISSION SCREENING TEAM.

Subpart 1. **General procedure for preadmission screening.** The preadmission screening team of the county of service must conduct the preadmission screening of a CADI

applicant as specified in parts 9505.2425, subparts 1; 2; 3, items A, B, C, and D; 4; and 14; and 9505.3020. Additionally, the preadmission screening team must:

A. inform the applicant about eligibility requirements for CADI as specified in part 9505.3035 and the services available through CADI;

B. give the person who is not a medical assistance recipient a medical assistance application and help the person complete the medical assistance application as required under parts 9505.0010 to 9505.0150; and

C. in the case of an applicant applying on or after October 1, 1989, who was not a nursing home resident on October 1, 1989, inform the applicant about the right of the applicant and the applicant's spouse to retain assets up to the amount specified in Minnesota Statutes, section 256B.059.

Subp. 2. **Local agency data sharing with lead agency.** Upon the lead agency's request, the local agency must provide the lead agency with information the local agency has concerning the medical assistance eligibility or social service needs of an applicant.

Subp. 3. **Team recommendations for CADI applicants.** After completing the assessment form required under part 9505.2425, subpart 1, and the assessment interview required under part 9505.2425, subpart 2, the team must recommend one of the choices in items A to E.

A. The team must recommend admission to a nursing home when:

(1) the assessment indicates that the applicant needs the level of care provided by a nursing home and that the home and community–based services that the applicant would need in lieu of nursing home care are not currently available; or

(2) the assessment indicates that the anticipated cost to medical assistance of providing the needed home and community–based services and medical assistance home care services would exceed the limit specified in part 9505.3040.

B. The team must recommend continued stay in a nursing home when:

(1) the assessment indicates that the resident needs the level of care provided by a nursing home and that the home and community–based services that the resident would need in lieu of nursing home care are not currently available; or

(2) the assessment indicates that the anticipated cost to medical assistance of providing the needed home and community–based services and medical assistance home care services would exceed the limit specified in part 9505.3040.

C. The team must recommend health and social services including CADI services and, if needed, medical assistance home care services when the assessment indicates that the applicant needs the level of care provided by a nursing home; the services needed by the applicant to be at home are available or can be developed; and the anticipated cost of providing the services is within the limit specified in part 9505.3040.

D. The team must recommend health and social services including CADI services and, if needed, medical assistance home care services when the assessment indicates that the applicant who is a nursing home resident needs the level of care provided by a nursing home; the home and community–based services needed by the applicant are available or can be developed; and the anticipated cost of providing the necessary services is within the limit specified in part 9505.3040.

E. The team must recommend that the applicant live in the community without home and community–based services if the assessment indicates that the person is not an applicant to or resident of a nursing home, does not require nursing home care, or does not need home and community–based services.

Subp. 4. **Application for CADI services; request for case manager.** If the team recommends the use of home and community–based services and the applicant chooses to remain in the community with the recommended services, the team must request that the person complete and sign an application for home and community–based services under CADI. To be eligible to receive CADI services, the person must also be eligible for medical assistance. If the person's eligibility for medical assistance has not been determined, a financial worker may accompany the team to the screening to take an application for medical assistance. If the applicant signs the application for home and community–based services under

CADI, the preadmission screening team must notify the lead agency and request the lead agency to assign a case manager.

Subp. 5. **Notice of preadmission screening team recommendation.** The preadmission screening team must give notice of the team recommendation made under subpart 3 as specified in part 9505.2425, subpart 8. Additionally, the team must obtain the consent of the applicant or, if appropriate, the applicant's representative for the purpose of notifying the applicant's physician.

Subp. 6. **Information to county of financial responsibility.** If the county of service is different from the county of financial responsibility, the preadmission screening team of the county of service must submit information about the applicant to the county of financial responsibility within ten working days after the preadmission screening is completed. The information must include:

A. a copy of the preadmission screening document;

B. a copy of the signed application required in subpart 4;

C. a copy of the preadmission screening assessment form;

D. a copy of the care plan as specified in part 9505.3030 that includes services to be provided and the estimated monthly cost of services; and

E. the person's medical assistance eligibility status.

Subp. 7. **County of financial responsibility action.** The county of financial responsibility shall review the information submitted by the preadmission screening team of the county of service and keep a file on the CADI applicant. The county of financial responsibility must sign off on the care plan and approve the application no later than ten days after receiving the information if the applicant meets the eligibility requirements in part 9505.3035 and has been assigned a slot by the department. Disputes about the county of financial responsibility must be resolved according to Minnesota Statutes, section 256G.09.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3030 INDIVIDUAL CARE PLAN.

Subpart 1. **Care plan development.** The case manager must develop a care plan on a form provided by the commissioner for an applicant who has chosen to remain in or return to the community and who is eligible for CADI services under parts 9505.3010 to 9505.3140. The case manager must develop the plan in consultation with:

A. the applicant;

B. the applicant's representative, if any; and

C. with the applicant's consent:

(1) the applicant's family;

(2) the primary caregiver if applicable;

(3) the applicant's physician; and

(4) any other individuals who are currently involved in meeting the applicant's health or community–living needs.

Subp. 2. **Care plan contents.** The care plan must include:

A. care objectives;

B. prescriptions for medications, restorative or rehabilitative services, diet, special procedures, and other health or community–living services recommended for the health or safety of the applicant;

C. a description of the health care and social services necessary to maintain the person in the community;

D. the frequency, scope, and duration of each of the services;

E. the designation of who will deliver each of the services described in the plan including both formal and informal providers;

F. the schedule for review and evaluation of the care plan;

G. an estimate of the total monthly cost of CADI and medical assistance services identified and recommended by the team as specified under part 9505.3025, subpart 3; and

H. the payment source for each service.

Subp. 3. **Directory of services.** In developing the recipient's care plan, the case manager must use the directory of services as specified in part 9505.2425, subpart 7.

Subp. 4. **Signatures on care plan.** The case manager shall request the applicant to sign the care plan specified in subpart 2 as an indication of the applicant's acceptance of the care plan. Additionally, the case manager must sign the care plan and, if authorized as in subpart 5, item D, request the recipient's physician to sign the recipient's care plan.

Subp. 5. **Distribution of care plan.** The case manager must give a copy of the applicant's or recipient's care plan to:

A. the county of service;

B. the county of financial responsibility;

C. the applicant or recipient; and

D. with the consent of the applicant or recipient, or the representative of the applicant or recipient, to the applicant's or recipient's physician and the provider or providers of the CADI services specified in the applicant's or recipient's care plan.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3035 ELIGIBILITY FOR CADI SERVICES.

Subpart 1. **Eligibility criteria.** A person is eligible for CADI services if the person meets the criteria in items A to L:

A. The person has been screened according to part 9505.3025.

B. The person is under age 65.

C. The person has been certified as disabled by the Social Security Administration or the state medical review team.

D. The person is a medical assistance recipient or is eligible for medical assistance under subpart 2 or parts 9505.0010 to 9505.0150.

E. The person would need the level of care provided in a nursing home if home and community–based services are not available.

F. The person is a nursing home applicant who chooses to remain in the community and use home and community–based services or is a nursing home resident who chooses to leave the nursing home and use home and community–based services.

G. The health and safety of the person is assured by providing home and community–based services.

H. The service needed by the person is not already provided as a part of a residential placement agreement. A residential services provider shall not provide CADI or medical assistance services without prior authorization from the commissioner. For purposes of this item, "residential placement agreement" means an agreement to provide a supervised living arrangement for the recipient, such as a foster care agreement between the county board and the provider. The recipient's case manager must document in the recipient's care plan all services to be provided to the recipient as part of the residential placement agreement. The term does not apply to residence in a long–term care facility.

I. The person needs community services that cannot be funded by sources other than CADI.

J. The cost of all CADI services and medical assistance funded nursing, home health aide, and personal care services including the supervision of personal care assistants; authorized in the care plan is less than the limitation in part 9505.3040.

K. The applicant or recipient accepts case management services.

L. The person has a written plan of care approved by the commissioner under part 9505.3055, subpart 1.

Subp. 2. **Determination of CADI applicant's medical assistance eligibility.** A CADI applicant's medical assistance eligibility must be determined under parts 9505.0010 to 9505.0150 except as specified in items A and B. For purposes of this subpart, "spend down" has the meaning given in part 9505.0015, subpart 44.

A. The local agency shall determine the applicant's eligibility for medical assistance without considering parental or spousal income and assets if the person meets the criteria in subpart 1, items A to L.

B. If an applicant's income exceeds the limits for medical assistance eligibility, the cost of CADI services and other medical services needed by the applicant must be used to meet the spend down required under part 9505.0065, subpart 11. The cost of a CADI service is considered to be incurred on the first day of the month in which the service is provided. The costs of other health services are applied to the spend down requirement as of the day on which the service is given. The applicant is responsible for paying bills used to meet the spend down.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3040 LIMIT ON COSTS OF RECIPIENT'S CADI SERVICES.

Subpart 1. **Costs to be applied toward the cost limit of a recipient's CADI services.** Except as provided in subpart 2, the costs of the following items must be applied toward the cost limit of a recipient's CADI services in subpart 3. The costs must be applied as specified in part 9505.3035, subpart 2:

A. costs of all CADI funded services, including case management, medical supplies and equipment, and adaptations; and

B. costs of home care services reimbursed by medical assistance.

Subp. 2. **Service costs to be excluded.** If reimbursed by medical assistance, the costs of the following items must be excluded from the costs included under subpart 1 to the extent that costs of these items are reimbursed by medical assistance:

A. prescription drugs;

B. medical transportation;

C. audiology, speech–language–pathology, respiratory, occupational, and physical therapy; and

D. medical supplies and equipment.

Subp. 3. **Monthly limit on costs of recipient's CADI services.** Except as provided in subpart 4, the monthly cost of CADI services to a recipient shall not exceed the statewide monthly average nursing home rate effective July 1 of the fiscal year in which the cost is incurred less the statewide average monthly income of nursing home residents who are less than age 65 and are medical assistance recipients in the month of March of the previous Minnesota fiscal year. In calculating the monthly limit for a recipient, the statewide monthly average nursing home rate shall be the rate of the resident class to which the recipient would be assigned under parts 9549.0050 to 9549.0059.

Subp. 4. **Exception to monthly limit on costs of recipient's CADI services.** If medical supplies and equipment or adaptations are or will be purchased for the recipient, the costs that are not reimbursable by medical assistance must be prorated on a monthly basis throughout the waiver year in which they are purchased. If the monthly cost of a recipient's other CADI services exceeds the limit in subpart 3, the annual cost of the CADI services shall be determined. In this event, the annual cost of CADI services to a recipient shall not exceed 12 times the monthly limit calculated under subpart 3.

Subp. 5. **Monthly limits on costs of CADI services of applicant who is a nursing home resident.** The monthly cost of CADI services for a person who is a nursing home resident at the time of requesting a determination of eligibility for CADI shall not exceed the monthly payment for the resident class assigned under parts 9549.0050 to 9549.0059 for that resident in the nursing home where the resident currently resides.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3045 REQUEST FOR PROVISIONAL CADI SLOT ASSIGNMENT.

When the case manager has completed a care plan as specified in part 9505.3030 and has determined that the applicant or recipient meets the requirements of part 9505.3035, the

case manager must contact the commissioner by phone and request the provisional assignment of a CADI slot pending the commissioner's determination under part 9505.3055. The request must include the following information:

A. the applicant's name;

B. the applicant's birth date;

C. the applicant's medical assistance ID number;

D. the applicant's resident class as specified in part 9505.3040, subpart 3;

E. the approximate date that services will begin; and

F. the estimated average monthly cost of home and community–based services funded by medical assistance and CADI.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3050 WRITTEN REQUEST FOR CADI SLOT ASSIGNMENT.

No later than 15 days after receiving a provisional CADI slot assignment under part 9505.3045, the lead agency must send to the commissioner a copy of the information specified in part 9505.3025, subpart 6, items A and D. If the required information is not submitted within the 15–day period, the department shall withdraw the provisional CADI slot assignment if there are other applicants eligible under part 9505.3035 who are waiting for a slot to be assigned. The department shall notify the lead agency if a provisional CADI slot assignment is ended.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3055 COMMISSIONER'S DETERMINATION.

Subpart 1. **Review and notice of decision.** The commissioner shall review the information and documents submitted by the lead agency under part 9505.3050 to determine whether the applicant is eligible for and approved to receive home and community–based services that are specified in the applicant's care plan and that are available under and paid for through CADI.

Subp. 2. **Criteria for commissioner's approval and assignment of CADI slot.** The commissioner shall approve a request for CADI services and assign a CADI slot in the order in which the application required under subpart 1 is received if the applicant meets the eligibility criteria in part 9505.3035 and a CADI slot is available.

Subp. 3. **Disapproval of request for CADI services.** The commissioner shall disapprove a request for CADI services if the applicant does not meet the eligibility criteria in part 9505.3035, a CADI slot is not available, or the information and documents submitted by the lead agency under part 9505.3050 are incomplete. If the information and documents submitted by the lead agency under part 9505.3050 are incomplete, the commissioner shall notify the lead agency of the action necessary to complete the application.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3060 REASSESSMENT OF CADI RECIPIENT.

Subpart 1. **Reassessment required.** The case manager must conduct a face–to–face reassessment of the health care needs of a CADI recipient at least once every six months after home and community–based services have begun. In addition to the six–month assessments, the case manager must reassess the health care needs of a CADI recipient when:

A. the case manager determines that changes in the health or community–living needs of the CADI recipient or changes in informal support arrangements necessary to remain at home require revisions in the recipient's care plan; or

B. a person who is eligible for CADI services has entered a nursing home for other than respite care or has entered a hospital for a temporary stay and is ready to return to the community.

Subp. 2. **Reassessment procedure.** The case manager must reassess the recipient as required under subpart 1 using the procedures specified for a preadmission screening in part 9505.3025.

Subp. 3. **Record of reassessment.** The case manager must place a record of the recipient's reassessment in the recipient's records at the lead agency. The record shall include the reason or reasons for the reassessment, the names of the persons consulted during the reassessment and their relationship to the recipient, revisions of the care plan and the reason or reasons for each revision or a statement that revisions were not needed. The revised care plan or statement must be signed by the recipient's physician.

Subp. 4. **Distribution of revised care plan.** The case manager must give a copy of the recipient's revised care plan to the entities specified in part 9505.3030, subpart 5.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3065 REIMBURSEMENT FOR CADI SERVICES.

The services in items A to J, as specified in parts 9505.3070 to 9505.3110, shall be reimbursed on a fee–for–service basis under CADI, if the services are provided according to a recipient's care plan, if the services are necessary to avoid the recipient's institutionalization, and if the rates for the services comply with the rates established in part 9505.3135:

A. case management services;

B. homemaker services;

C. respite care services;

D. adult day care services;

E. extended home health services;

F. extended personal care services;

G. adaptations;

H. independent living skills services;

I. family support services; and

J. other services if authorized under the waiver.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3068 COSTS NOT ELIGIBLE FOR REIMBURSEMENT UNDER CADI.

The costs of the following services shall not be reimbursed under the CADI program:

A. community services that can be reimbursed through other funding sources including Medicare and third–party payers as defined in part 9505.0015, subpart 46;

B. room and board costs except for respite care provided away from the recipient's residence;

C. services of providers who are not under contract with the county;

D. respite care services that exceed the 720–hour limit in part 9505.3110;

E. adaptations that cost more than allowed by the waiver per recipient;

F. services not authorized by the case manager;

G. supplementary or replacement services covered by a Medicare or medical assistance funded hospice program, except services for a condition not related to the terminal illness; or

H. payment for CADI services provided to a nursing home resident before the date of discharge from the nursing home.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3070 CASE MANAGEMENT SERVICES.

Subpart 1. **Case management services required.** Case management services are required under CADI. The lead agency must assure that a case manager is designated to provide case management services to each recipient.

Subp. 2. **Case manager qualifications.** Case management services must be provided by a registered nurse as defined in part 9505.3015, subpart 41, or a social worker as defined in part 9505.3015, subpart 48.

A person who provides case management services must be employed by or under contract with the lead agency. The lead agency shall monitor and enforce compliance with the terms of the contract.

Subp. 3. **Responsibilities of case manager.** The case manager must:

A. assure that the team uses the criteria of the Preadmission Screening Assessment document in screening applicants;

B. develop the care plan with the screening team, the applicant, and the applicant's family members and other appropriate persons;

C. obtain the necessary documentation of service need, including the attending physician's signature;

D. authorize the provision of services specified in the recipient's approved case plan;

E. monitor service providers and the provision of services to ensure that only the authorized care is being provided and that the recipient's health and safety at least is being maintained;

F. with the consent of the applicant or recipient or the representative of the applicant or recipient, initiate and maintain contact with family members and other informal caregivers to ensure that planned care, both formal and informal, is being provided;

G. assist the recipient in gaining access to needed medical, social, educational, and other services;

H. reassess a CADI recipient as required under part 9505.3060;

I. complete a notice of action form (DHS–2828) if the recommendations of the preadmission screening team following a reassessment under part 9505.3060 are to reduce, suspend, or terminate the recipient's CADI services. The original notice of action must be sent to the recipient no later than ten days before the proposed action;

J. monitor the recipient's health and safety;

K. contact the local agency to verify that the person is eligible for medical assistance; and

L. provide ongoing coordination of the care plan so the cost does not exceed cost limits of part 9505.3040.

Subp. 4. **Reporting suspected abuse or neglect of a vulnerable adult or suspected maltreatment of a child.** A case manager who has reason to believe a recipient who is an adult is or has been subject to abuse or neglect as defined in Minnesota Statutes, section 626.557, subdivision 2, must immediately comply with the reporting and other actions required under Minnesota Statutes, section 626.557. A case manager who has reason to believe a recipient, who is a child, is or has been subject to maltreatment as defined in Minnesota Statutes, section 626.556, must immediately comply with the reporting and other actions required under Minnesota Statutes, section 626.556. The case manager must determine how to assure the recipient's health and safety during the investigation, and may take one or more of the actions specified in subpart 5. The case manager must request a report from the protection agency in order to take the action required in subpart 5 unless the recipient's health and safety is imminently threatened.

Subp. 5. **Case manager decisions.** When the case manager receives the findings of the investigation conducted under Minnesota Statutes, section 626.556 or 626.557, the case manager shall amend the care plan as needed to assure the recipient's health and safety. Based on the findings, the case manager shall determine whether:

A. to arrange for the services of another CADI provider;

B. to work out alternative housing and services for the recipient; or

C. to suspend or terminate the CADI services. Notwithstanding any rule to the contrary, if the case manager decides to suspend or terminate the recipient's CADI services, the suspension or termination shall take effect upon the date of the notice of the suspension or termination to the recipient.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3075 ADAPTATIONS.

An adaptation is available to a recipient under CADI only if the adaptation is necessary to enable a recipient with mobility problems, sensory deficits, or behavior problems to be maintained at home. Adaptations include minor physical adaptations to the home, adaptive equipment, and minor adaptations to vehicles provided to enable disabled persons to live in the community. Examples of adaptations to the home are widened doors, handrails, lifting devices, and ramps. Examples of adaptations to a vehicle are lifting devices, wheel chair securing devices, and adapted seats. For purposes of this part, "minor physical adaptation" means an adaptation that costs less than the limit specified in the waiver. Adaptations can be provided under the CADI waiver for a recipient if:

A. the adaptation is not available from any other funding source and has a cost within the limitations specified in parts 9505.3010 to 9505.3140; and

B. the case manager has received prior authorization from the commissioner. To obtain authorization, the case manager must document that the adaptation is necessary for the recipient to avoid nursing home admission and the cost of the adaptation is within the limit specified in the waiver.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3080 ADULT DAY CARE SERVICES.

Adult day care services are available under CADI. Adult day care services are to be offered only when the services are necessary to avoid the recipient's admission to a nursing home. Adult day care services provided through CADI must meet the criteria in items A and B.

A. The services must be furnished on a regularly scheduled basis and cannot exceed 12 hours in a 24–hour period.

B. If the adult day care service provides transportation, then the cost of transportation to and from the site of the adult day care service is eligible for payment under CADI if it is included in the day care rate.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3085 EXTENDED HOME HEALTH SERVICES.

Extended home health services are available under CADI if the services meet the requirements in items A to C.

A. The service is a home health service as specified in part 9505.0295 except that the limits in subpart 3 of part 9505.0295 on the number of visits and hours eligible for medical assistance reimbursement do not apply.

B. The service is provided according to the amount, duration, and scope specified in the recipient's care plan.

C. The service is provided by a provider who meets the requirements of part 9505.0290, subpart 2.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3090 EXTENDED PERSONAL CARE SERVICES.

Subpart 1. **Availability under CADI.** Extended personal care services are available under CADI if the extended personal care services meet the requirements in part 9505.0335 except as provided in subparts 2 and 3 and except that the directions for the recipient's care may be provided by a primary caregiver or family member if the recipient is not able to direct his or her own care.

Subp. 2. **Qualification as personal care assistant.** A person who does not qualify as a personal care assistant under part 9505.0335 can be a personal care assistant for a recipient if the person meets the training requirements under part 9505.0335, subpart 3, and is employed by or under contract with the lead agency.

Subp. 3. **Relative as personal care assistant.** A recipient's relative, other than a responsible relative as defined in part 9505.0015, subpart 43, may be employed as a personal care assistant if the relative meets the requirements in subpart 2, is under contract with the lead agency, and meets one of the financial hardship criteria in items A to D:

A. the relative resigns from a full–time job to care for the recipient;

B. the relative goes from a full–time to a part–time job with less compensation;

C. the relative takes a leave of absence without pay to provide personal care for the recipient; or

D. the relative, because of local labor conditions, is the only person available to provide care for the recipient.

Subp. 4. **Commissioner's approval of extended personal care services.** The lead agency must obtain the department's approval to provide extended personal care services to a recipient.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3095 FAMILY SUPPORT SERVICES.

Subpart 1. **Availability as CADI service.** Family support services that are the training and counseling services in items A and B are available under CADI. The services may be provided to the recipient as well as to persons with whom the recipient lives or who routinely are the recipient's informal caregivers.

A. Training must be designed to increase the recipient's or family member's ability to care for the recipient at home and must be necessary to avoid the recipient's admission to a nursing home. Training includes instruction about the use of equipment and treatment regimens that are specified in the recipient's care plan.

B. Counseling includes helping the recipient or members of the recipient's family with crises, coping strategies, and stress reduction as required for family functioning to maintain the recipient in the community.

Subp. 2. **Standards to be a CADI provider of training services.** A provider of training services under CADI must meet the applicable qualification specified in items A to H.

A. A physician must be licensed to practice in Minnesota.

B. A registered nurse must be licensed and have one year of experience as a professional nurse.

C. A physical therapist must have a current Minnesota certificate of registration.

D. An occupational therapist must be currently certified by the American Occupational Therapy Association as an occupational therapist.

E. A respiratory therapist must meet the criteria established for a respiratory therapist in part 9505.0295, subpart 2, item E.

F. A medical equipment supplier must be authorized by the case manager to provide training in use of equipment and must be a provider under part 9505.0195.

G. A speech–language pathologist must be certified by the American Speech–Language–Hearing Association.

H. A nutritionist must have a bachelor's degree and be registered by the Commission on Dietetic Registration.

Subp. 3. **Standards for providers of family support counseling services.** A provider of family support counseling services must be one of the following:

A. a Medicaid enrolled psychiatrist or individual who works under the supervision of a Medicaid enrolled psychiatrist;

B. a Medicaid enrolled psychologist or individual who works under the supervision of a Medicaid enrolled psychologist;

C. a mental health clinic that is an enrolled Medicaid provider;

D. a social worker licensed under Minnesota Statutes, sections 148B.18 to 148B.28; and

E. an independent practitioner who provides counseling services and who has been determined by the lead agency to:

(1) have a general knowledge of disabilities and chronic illnesses that may affect individual or family functioning;

(2) have skills in mental health assessment, including client interviewing and screening;

(3) have skills in mental health management including treatment planning, general knowledge of social services, record keeping, reporting requirements, confidentiality rules, and any federal or state regulations which apply to mental health services;

(4) have skills in individual and group counseling, including crisis intervention; and

(5) provide proof that:

(a) The individual possesses at least a bachelor's degree with a major in social work, nursing, sociology, human services, or psychology and has successfully completed 960 hours of experience as a counselor supervised by a licensed psychiatrist or psychologist. The experience can be either as a student, volunteer, or employee.

(b) The individual has successfully completed a minimum of:

i. 40 hours of classroom training in a health related field;

ii. 40 hours of classroom training in mental health assessment including interviewing skills;

iii. 40 hours of classroom training in mental health management including treatment planning, social services, record keeping, reporting requirements, and confidentiality;

iv. 40 hours of classroom training in individual and group counseling techniques; and

v. successful completion of 960 hours of experience as a counselor supervised by a licensed psychiatrist or licensed psychologist as either a student, volunteer, or employee; or

(c) The individual possesses training in unit (b), subunits (i) to (iii), and has successfully completed two years of supervised experience as a counselor or therapist.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3100 HOMEMAKER SERVICES.

Subpart 1. **Availability as CADI service.** Homemaker services are available under CADI. Homemaker services must be designed to enable a recipient to remain at home and avoid admission to a nursing home and must be provided if authorized by the case manager.

Subp. 2. **Tasks of homemaker.** Homemaker services include:

A. house cleaning;

B. laundering and ironing;

C. meal planning and preparation;

D. dishwashing;

E. household management;

F. providing companionship, emotional support, and social stimulation;

G. observing and evaluating home safety practices and improving these practices where appropriate;

H. monitoring the safety and well being of the recipient; and

I. performing essential errands and shopping.

Subp. 3. **Qualified homemakers.** The lead agency shall assure that each recipient receiving homemaker services is served by a homemaker qualified under part 9565.1200, subpart 2.

Subp. 4. **Contracting for homemaker services and supervision.** The lead agency may directly provide or contract for homemaker services for a recipient as indicated in the recipient's care plan. If the lead agency provides homemaker services directly, the lead agency must also provide supervision of the homemaker's activities. If the lead agency con-

tracts with a provider for homemaker services, the provider must meet the requirements of Minnesota Statutes, sections 144A.43 to 144A.46.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3105 INDEPENDENT LIVING SKILLS SERVICES.

Subpart 1. **Availability as CADI services.** Independent living skills services are available under CADI. Independent living skills services may be provided in the disabled person's home or at a site approved by the case manager. Independent living skills services must be directed at the development and maintenance of community living skills and community integration.

Subp. 2. **Standards for providers of independent living skills services.** Providers of independent living skills services may include the following:

A. home health agencies enrolled as Medicaid providers;

B. rehabilitation agencies enrolled as Medicaid providers;

C. a person who is employed by an independent living center and who is determined by the lead agency to meet the requirements in subitems (1) to (5). For purposes of this item, "independent living center" means a center that meets the requirements of parts 3300.3100 to 3300.3270.

(1) has general knowledge of disabilities and chronic illnesses which affect an individual's ability to live independently in the community;

(2) has the ability to do a needs assessment of the skills a disabled individual must develop in order to live independently in the community;

(3) has knowledge of independent living skills management including service planning, general knowledge of social services, record keeping, reporting requirements, and confidentiality;

(4) has the ability to provide assistance, supervision, and training in the area of independent living; and

(5) provides proof that the person:

(a) has a bachelor's degree with a major in nursing, physical therapy, occupational therapy, or speech–language pathology, psychology, or sociology, and has successfully completed 480 hours of experience working with disabled or chronically ill individuals as a student, volunteer, or employee, under the supervision or direction of a licensed physician;

(b) has successfully completed an accredited educational program for registered nurses or licensed practical nurses;

(c) has completed a nursing assistant training program or its equivalent for which competency as a nursing assistant is determined by the State Board of Technical Colleges;

(d) has completed a homemaker or home health aide preservice training program using a curriculum recommended by the Minnesota Department of Health and whose supervisor has determined that the individual has the skills required to provide the independent living skills services as stated in the care plan; or

(e) has received a minimum of:

i. five hours of classroom training in recognizing the symptoms and effects of certain disabilities and health conditions;

ii. 20 hours of classroom instruction in providing supervision of, training to, and assistance with independent living skills services; and

iii. a determination by the person's supervisor that the individual has the skills required to provide the independent living skills services stated in the care plan.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712; L 1990 c 375 s 3*

9505.3107 MEDICAL SUPPLIES AND EQUIPMENT.

Subpart 1. **Availability as a CADI service.** Medical supplies and equipment are available as one of the extended home health services under CADI. The lead agency may buy or

rent care–related medical supplies and equipment for a recipient if the medical supplies and equipment are specified in the recipient's approved care plan and are beyond the amount, scope, and duration available as covered services under parts 9505.0170 to 9505.0475; and the case manager has received prior authorization from the commissioner to use CADI funds.

Subp. 2. **Criteria to obtain commissioner's prior authorization.** To obtain prior authorization, the case manager must document that the medical supply or equipment is necessary to enable the recipient to remain in the community and is beyond the amount, scope, and duration available as a covered service under parts 9505.0170 to 9505.0475; and the cost of the medical supply or equipment is within the limitation specified in the waiver. "Prior authorization" means the commissioner's approval given to a lead agency before the lead agency purchases or rents the item.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3110 RESPITE CARE SERVICES.

Subpart 1. **Availability as CADI service.** Respite care services are available under CADI. Respite care is limited to 720 hours per person per waiver year.

Subp. 2. **Provider standards.** Respite care may be provided in either an out–of–home setting or in the recipient's own home.

A. Out–of–home respite care must be provided in a facility approved by the county such as a hospital, nursing home, foster home, or community residential facility. When respite care is provided in a non–Medicaid certified facility, that facility must meet applicable state licensure standards.

B. In–home respite care providers must be individuals who meet the state qualifications required of registered or licensed practical nurses, home health aides, or personal care assistants who have been specifically trained to provide care to the recipient. Respite care workers must have had first aid training and cardiopulmonary resuscitation training. A respite care worker who is a home health aide or personal care assistant must be under the supervision of a registered nurse. The registered nurse must assure that the respite care worker is able to read and follow instructions, able to write clear messages, and has a level of skill required by the recipient's needs.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3115 STANDARDS FOR PROVIDER REIMBURSEMENT.

Lead agencies must assure that providers of all CADI services are qualified under parts 9505.0170 to 9505.0475 and 9505.3010 to 9505.3140 to provide the necessary service. In addition, a provider shall receive reimbursement for CADI services only if the provider meets the criteria in items A to D.

A. The provider must have current Minnesota certification or licensure for the specific CADI service if Minnesota Statutes or Minnesota Rules require certification or licensure.

B. The provider must assure that the provider and all employees or subcontractors meet the standards established in the waiver that apply to the services provided or in Minnesota Statutes, chapters 144A, 146, and 148; parts 9505.0170 to 9505.0475; and Code of Federal Regulations, title 42, sections 440.180 and 440.300 to 440.310.

C. The provider must be employed by or have contracted with the lead agency to provide CADI services.

D. The provider must be reimbursed only for services authorized by the case manager as part of the recipient's care plan.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3120 LEAD AGENCY SELECTION OF CADI PROVIDERS.

Subpart 1. **Solicitation of providers.** The lead agency must solicit providers for all CADI services. The solicitation may be by written notice, a request for proposal, or as part of

the annual public meeting required by Minnesota Statutes, section 256B.091, subpart 8, and part 9505.2460, subpart 1. If the lead agency chooses to use a written notice, the lead agency must place the notice in the newspaper that is the official newspaper designated by the county board of commissioners of the local agency under Minnesota Statutes, section 279.08. The notice must state the type of services for which a need is anticipated, the criteria in subpart 2 for selection as a CADI provider, the date by which the lead agency will complete its selection of CADI providers, and the name, telephone number, and address of the lead agency's contact person who can provide information about the criteria for selection and contract terms.

Subp. 2. **Selection factors.** The lead agency must contract with all providers that meet the standards to provide CADI services under parts 9505.3010 to 9505.3140. The lead agency must consider items A to G:

A. the need for the particular service offered by the provider;

B. the ability of the provider to meet the service needs of CADI recipients in the county;

C. the geographic area to be served by the provider;

D. the quality assurance methods to be used by the provider including compliance with required licensure, certifications, or standards and supervision of employees as required by parts 9505.3090 to 9505.3120;

E. the provider's agreement to provide the CADI service at a fee that is at or less than the county's maximum reimbursement rate for the service;

F. services previously or currently delivered by the provider; and

G. the provider's previous compliance with contract provisions and the provider's future ability to comply with contract provisions including billing requirements, and terms related to contract cancellation and indemnification.

Subp. 3. **Written record of reason for not selecting a provider.** A lead agency must keep a written record of the reason a provider who requests a contract to provide CADI services was not selected and must notify the provider of the reason.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3125 CONTRACTS FOR CADI SERVICES.

Subpart 1. **Contract required.** To receive reimbursement for CADI services, the provider must be employed by or have a contract with the lead agency.

Subp. 2. **Compliance with applicable laws and regulations required.** The lead agency must have a medical assistance provider agreement according to part 9505.0195. The lead agency and any provider of services under parts 9505.3010 to 9505.3140 that is employed by or under contract to the lead agency must comply with Code of Federal Regulations, title 42; Minnesota Statutes, chapter 256B; and all applicable department rules relating to medical assistance providers.

Subp. 3. **Information required in contract.** The contract must contain:

A. the estimated number of CADI recipients to be served by the provider;

B. an agreement to comply with parts 9505.3010 to 9505.3140;

C. an agreement to comply with the Minnesota Government Data Practices Act;

D. the beginning and ending dates for the term of the contract;

E. an agreement to comply with the care plan as set forth by the case manager;

F. the amount that the lead agency shall pay the provider for the services;

G. the conditions under which the lead agency shall terminate the provider's contract;

H. documentation of an individual abuse prevention plan that complies with parts 9555.8000 to 9555.8500 in the case of adults or with parts 9560.0210 to 9560.0234 in the case of children;

I. a description of the reports the provider must give the lead agency;

J. a description of the records the provider must keep; and

K. other provisions the county board determines are needed to ensure the county's ability to comply with part 9525.1900.

Subp. 4. **Subcontracts.** If the provider subcontracts with another contractor the provider must:

A. have written permission from the lead agency to subcontract;

B. ensure that the subcontractor meets all the requirements of subparts 2 and 3 in the same manner as those requirements apply to all providers; and

C. ensure that the subcontractor performs fully the terms of the subcontract.

Subp. 5. **Noncompliance.** If the provider or subcontractor fails to comply with the contract, the lead agency must notify the local agency and request the county board to take appropriate action. Upon receiving the request, the county board shall seek any available legal remedy. The county board shall notify the commissioner in writing within 30 days of receiving information that provides the county board with reasonable grounds to believe that a contract required under this part has been breached in a material manner or that a provider or subcontractor has taken any action or failed to take any action that constitutes anticipatory breach of the contract. The county board may allow the provider or subcontractor a reasonable amount of time to cure the breach or anticipatory breach. The county board shall notify the commissioner in writing within ten working days if the provider or subcontractor takes any action or fails to take any action in response to the opportunity to cure. In the notice, the county board shall inform the commissioner of the action the county board intends to take.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3130 AGENCY REPORTS AND RECORDS.

Subpart 1. **County plans.** The lead agency must submit an annual county plan for CADI services on forms provided by the commissioner. The lead agency must submit the county plan to the commissioner by August 1 of each year for the lead agency to receive reimbursement for CADI services during the next waiver year. The lead agency must submit revisions of the county plan to the commissioner for approval before implementing the revisions. The submitted plan or a revision of a plan must be signed by the person authorized by the county board. The county plan must include items A to J:

A. name and address of the lead agency;

B. name, address, and telephone number of the administrative contact within the lead agency;

C. a description of how the agency will make sure that the actual cost of services per individual per waiver year will not exceed the limits specified in part 9505.3040;

D. criteria and method used to notify and select providers;

E. proof that all services covered by the waiver will be available in the community;

F. a description of how the agency will make sure that CADI clients are applicants for admission to, or residents of, nursing homes;

G. a description of how the agency will make sure that clients are given a choice of institutional or community care according to part 9505.3025, subpart 3;

H. a description of how the agency will make sure that the safety and health of clients served by the waiver will be protected;

I. a description of how the agency will comply with the Minnesota Government Data Practices Act; and

J. a description of how the local agency will comply with subpart 4 in regard to provider records.

Subp. 2. **Resubmission of conditional approvals or rejections.** If a county plan is conditionally approved or rejected, the revised plan must be submitted within 30 days or reimbursement for CADI services will be suspended until the plan is fully approved. However, the county must continue to pay for CADI services using county funds until a county plan has been approved.

Subp. 3. **Provider agreements.** A county participating in the CADI program must designate a lead agency and must submit an enrollment form and a signed provider agreement

that enrolls the lead agency as a CADI provider eligible to receive medical assistance payment for CADI services. The enrollment and signed provider agreements must be on forms provided by the commissioner.

Subp. 4. **CADI provider records.** The lead agency and a CADI provider under contract with the lead agency must maintain complete program and fiscal records and supporting documentation identifying the CADI recipients served, the services provided, and the costs incurred. The records must be identified and maintained separately from other provider records. The lead agency's and the providers' records are subject to the maintenance schedule, audit availability requirements, and other provisions in parts 9505.2160 to 9505.2245.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3135 RATES FOR CADI SERVICES.

Subpart 1. **Notices to lead agencies.** By June 1 of each year, the commissioner shall notify a lead agency of the statewide maximum rate allowed for reimbursement of a CADI service under subpart 2.

Subp. 2. **Maximum CADI service rate.** The commissioner shall annually set the maximum rate available to a county to reimburse a provider for a CADI service other than a case management service. The rates for CADI services other than a case management service shall be adjusted for each waiver year based on medical assistance rates for equivalent services. For services that do not have a medical assistance payment rate under part 9505.0445, for years beginning on July 1, 1990, the commissioner shall authorize an adjustment in the CADI rate (available to a county as reimbursement to a CADI provider) up to the percentage change forecast in the first quarter of the calendar year by the Home Health Agency Market Basket of Operating Costs, Health Care Costs. The Home Health Agency Market Basket of Operating Costs, Health Care Costs is published by Data Resources, Inc. McGraw–Hill and is subject to quarterly updating. The Home Health Agency Market Basket of Operating Costs, Health Care Costs, is incorporated by reference and is available for inspection at the department, Division of Reports and Statistics, Third Floor, 444 Lafayette Road, St. Paul, Minnesota 55101 and through the Minitex interlibrary loan system.

Subp. 3. **County CADI service rate.** A county may set rates for CADI services not to exceed the rates established in subpart 1. County rates are subject to audit by the commissioner. Administrative costs are part of the case management rate and are to be included in the case management rate and not added to the county rate for other services.

Subp. 4. **Supervision costs.** The cost of supervision for all services except extended personal care must be included in the rate unless payment for the supervision is included in the rate for skilled nursing services. Supervision of personal care services shall be paid according to the rate specified in part 9505.0445, item K, for private duty nursing performed as a supervisory visit by a private duty nurse.

Subp. 5. **Recovery of costs.** The county of service must monitor use and costs of CADI services. According to part 9505.0195, subpart 6, the county of service must pay the commissioner the amount by which the costs exceed the limits specified in part 9505.3040.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3138 CRITERION FOR DELAY IN SENDING REQUIRED NOTICES.

If information that the commissioner needs to prepare and send the notices required under parts 9505.3010 to 9505.3140 is not provided in time for the commissioner to meet the time specified in parts 9505.3010 to 9505.3140, the required notices shall be sent as soon as possible after the commissioner receives the needed information.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3139 BILLING FOR CADI SERVICES.

A provider of CADI services must submit a claim to the lead agency through the CADI recipient's case manager for payment for a CADI service specified in a CADI recipient's care

plan. A claim under this part must not exceed the amount specified in the contract between the CADI provider and the lead agency that is required under part 9505.3125. The CADI provider must submit the claim for payment according to the billing procedures in part 9505.0450, however, the claim shall not be submitted directly to the department.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3140 APPEALS.

Subpart 1. **Notice of right to appeal.** A person assessed or reassessed under part 9505.3060 has the right to appeal action described in subpart 2. The case manager must provide the person or the person's representative with written information about the right to appeal. The information must state the grounds for an appealable action and must state that CADI services will not be reduced, suspended, or terminated if the appeal is filed before the date specified in the information unless the person requests in writing not to receive CADI services while the appeal is pending.

Subp. 2. **Appealable actions.** A person being assessed or reassessed under part 9505.3060, may appeal if the following actions are taken by the agency:

A. CADI services are denied;

B. eligibility for CADI services is not determined with reasonable promptness; and

C. CADI services are reduced, suspended, or terminated.

Subp. 3. **Actions that are not appealable.** A denial, reduction, suspension, or termination of CADI services is not an appealable action if the following conditions apply:

A. the person is a nursing home resident but the cost of home care would exceed the cost of nursing home care;

B. the person is an applicant for admission to a nursing home but the costs of the CADI services exceed the limit in part 9505.3040;

C. there are no slots available for CADI services; or

D. the waiver is terminated.

Subp. 4. **Submission of appeals.** The person being assessed or reassessed who wants to appeal must submit the appeal in writing to the lead agency of the county of service or to the department within 30 days after receiving written notice of the appealable action, or within 90 days of the written notice if a good cause for delay can be shown.

Subp. 5. **Hearing of appeal.** An appeal of issues meeting the criteria under subparts 1, 2, and 4 shall be heard and decided according to Minnesota Statutes, section 256.045.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

COMMUNITY ALTERNATIVE CARE PROGRAM

9505.3500 APPLICABILITY AND EFFECT.

Subpart 1. **Applicability.** Parts 9505.3500 to 9505.3700 establish standards and procedures applicable to the community alternative care (CAC) program. Individuals who are eligible for and receiving medical assistance services may also be eligible for and receive services under the community alternative care program. CAC pays for approved home and community–based services in lieu of hospital admission or continued hospitalization for individuals who meet the requirements of parts 9505.3500 to 9505.3700, Minnesota Statutes, section 256B.49, and the Code of Federal Regulations, title 42, section 441.302(e)(2). Parts 9505.3500 to 9505.3700 must be read in conjunction with Minnesota Statutes, chapter 256B; parts 9500.1070, subparts 1 and 12 to 15; 9500.1090 to 9500.1155; chapter 9505; Title XIX of the Social Security Act; and title 42 of the Code of Federal Regulations; and the requirements of the waiver obtained by the state from the United States Department of Health and Human Services.

Parts 9505.3500 to 9505.3700 apply to local agencies administering medical assistance funds and providing case management services; entities and organizations contracting to

perform functions under Minnesota Statutes, 256B.49; providers of home and community–based services who are paid or who request payment under parts 9505.3500 to 9505.3700; and CAC applicants and recipients.

Subp. 2. **Effect.** References to the waiver and waiver provisions that occur in parts 9505.3500 to 9505.3700 shall continue in effect only as long as the waiver from the United States Department of Health and Human Services is in effect in Minnesota.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3510 DEFINITIONS.

Subpart 1. **Applicability.** The definitions in this part apply to parts 9505.3500 to 9505.3700.

Subp. 2. **Acting case manager.** "Acting case manager" means a person who is a public health nurse, medical social worker, social worker, or registered nurse who is appointed by the department and performs case management services specified in subpart 6 for an applicant until the applicant's eligibility for CAC services is determined and a case manager is assigned.

Subp. 3. **Applicant.** "Applicant" means an individual who has submitted an application to participate in the CAC program rather than reside in a hospital or remain at risk of frequent hospitalization.

Subp. 4. **Application.** "Application" means an application to participate in CAC that is completed according to part 9505.3540.

Subp. 5. **Assessment.** "Assessment" means the process an interdisciplinary team uses to identify an applicant's health service needs according to part 9505.3540 so that the team can determine the appropriateness of home and community–based services in meeting the applicant's needs.

Subp. 6. **Case management services.** "Case management services" means services in which a case manager identifies, arranges, authorizes, and coordinates health services including home and community–based services under parts 9505.3500 to 9505.3700 for a recipient; monitors the delivery of services; adjusts services to the needs of the recipient; and advocates for the rights of the recipient.

Subp. 7. **Case manager.** "Case manager" means a social worker, registered nurse, or public health nurse who is employed by or under contract with the lead agency and who performs case management services.

Subp. 8. **Chronically ill individual or individual.** "Chronically ill individual" or "individual" means an individual who needs an extensive array of health services for an undetermined period of time, whose health condition requires frequent monitoring and treatment by a health care professional or by a person supervised by a health care professional, and who would reside in a hospital or require frequent hospitalization if these services were not provided.

Subp. 9. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designated representative.

Subp. 10. **Community alternative care program or CAC.** "Community alternative care program" or "CAC" means the program specified in the Minnesota Medicaid model waiver approved by the United States Department of Health and Human Services to provide home and community–based services to chronically ill individuals under age 65.

Subp. 10a. **Counseling and training services.** "Counseling and training services" means counseling and training approved by the case manager for primary caregivers in issues pertaining to the maintenance of the recipient in the home. Examples of counseling are crisis counseling and family or individual counseling as required for family functioning. An example of training is teaching a family member or other primary caregiver a treatment regimen or how to use medical equipment or other adaptive equipment necessary to avoid institutionalization.

Subp. 11. **County of financial responsibility.** "County of financial responsibility" has the meaning given it in Minnesota Statutes, section 256G.02, subdivision 4.

Subp. 12. **County of service.** "County of service" means the county that performs or arranges services for recipients under parts 9505.3500 to 9505.3700. County of service may be either the county of financial responsibility or the county in which the recipient resides.

Subp. 13. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 14. **Durable medical equipment.** "Durable medical equipment" means a device that can withstand repeated use, is provided to correct or accommodate a physiological disorder or physical condition, and is suitable for use in the recipient's residence.

Subp. 15. **Environmental modifications to the home.** "Environmental modifications to the home" means structural changes to a recipient's residence that are prescribed in the recipient's care plan and that are necessary to maintain the recipient in the recipient's home. Examples of environmental modifications are changes in electrical wiring to accommodate equipment, construction of wheelchair ramps, and widening of doors.

Subp. 16. **Foster care services.** "Foster care services" means ongoing residential care and supportive services provided to a recipient living in a foster home licensed under parts 9545.0010 to 9545.0260 or 9555.5105 to 9555.6265.

Subp. 17. **Health care professional.** "Health care professional" means a physician, registered nurse, licensed practical nurse, occupational therapist, physical therapist, respiratory therapist, or a speech–language pathologist.

Subp. 18. **Health service.** "Health service" means a medically necessary service that is ordered by a physician, documented in an approved care plan, and provided to a recipient as ordered in the care plan. The term includes home and community–based services and services provided under parts 9505.0170 to 9505.0475.

Subp. 19. **Home.** "Home" means the recipient's residence as defined in part 9505.0175, subpart 43. "Home" does not include a hospital or long–term care facility.

Subp. 20. **Home and community–based services.** "Home and community–based services" means the services listed in items A to L that are available under the waiver to recipients:

A. case management services under part 9505.3560;
B. home health services under part 9505.3570;
C. homemaker services under part 9505.3575;
D. respite care services under part 9505.3580;
E. physician services under part 9505.3585;
F. family counseling and training under part 9505.3600;
G. environmental modifications in the home under part 9505.3610;
H. medical equipment under part 9505.3620;
I. medical transportation under part 9505.3622;
J. prescribed drugs under part 9505.3624;
K. other professional services under part 9505.3626; and
L. foster care services under part 9505.3630.

Subp. 21. **Home care plan or care plan.** "Home care plan" or "care plan" means the written plan of health services provided to a recipient that are necessary to maintain a recipient in the recipient's home.

Subp. 22. **Home health aide.** "Home health aide" means a person who meets the standards for a home health aide in part 9505.0290, subpart 3.

Subp. 23. **Homemaker.** "Homemaker" means a person who provides homemaker services and is qualified according to part 9565.1200, subpart 2.

Subp. 24. **Homemaker services.** "Homemaker services" means the activities specified in parts 9565.1100 and 9565.1200 that are prescribed in the recipient's care plan and provided by a homemaker.

Subp. 25. **Hospital.** "Hospital" has the meaning given in Minnesota Statutes, section 144.696, subdivision 3.

Subp. 26. **Interdisciplinary team or team.** "Interdisciplinary team" or "team" means a team specified in part 9505.3535 that is responsible for developing a home care plan for an applicant or for a recipient.

Subp. 27. **Lead agency.** "Lead agency" means the county welfare department or public health agency designated by the local agency to administer CAC.

Subp. 28. **Licensed practical nurse.** "Licensed practical nurse" means a person licensed under and providing health services within the scope of Minnesota Statutes, section 148.29.

Subp. 29. **Local agency.** "Local agency" means the county or multicounty agency that is authorized under Minnesota Statutes, section 256B.05 to administer the medical assistance program, including the community alternative care program.

Subp. 30. **Medical assistance.** "Medical assistance" means the program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 31. **Medical social worker.** "Medical social worker" means a graduate of a school of social work accredited by the Council on Social Work Education who has had social work experience in a hospital, outpatient clinic, medical rehabilitation, or medical care program.

Subp. 32. **Medically necessary.** "Medically necessary" has the meaning given in part 9505.0175, subpart 25.

Subp. 33. **Nondurable medical equipment.** "Nondurable medical equipment" means a supply or piece of equipment that is used to treat a health condition and that cannot be reused.

Subp. 34. **Nursing services.** "Nursing services" means services ordered by a physician, specified in the recipient's care plan, and provided by a licensed practical nurse or provided by a registered nurse or provided under the supervision of a registered nurse.

Subp. 35. **Nutritionist.** "Nutritionist" means a person who at a minimum has a bachelor's degree in nutrition and foods or a closely related field and is registered as a dietitian with the Commission of Dietetic Registration.

Subp. 36. **Occupational therapist.** "Occupational therapist"means a person who is currently registered as an occupational therapist with the American Occupational Therapy Association or who is a graduate of a program in occupational therapy approved by the Council of Medical Education of the American Medical Association in collaboration with the American Occupational Certification Board and who is acquiring the supervised clinical experience prerequisite to registration by the American Occupational Therapy Association.

Subp. 37. **Physical therapist.** "Physical therapist" means a person holding a current Minnesota certificate of registration as a physical therapist.

Subp. 38. **Physician.** "Physician" means a person who is licensed to provide health services within the scope of the physician's profession under Minnesota Statutes, chapter 147.

Subp. 39. **Prescribed drug.** "Prescribed drug" means a drug as defined in Minnesota Statutes, section 151.01, subdivision 5, authorized by the recipient's physician, and specified in the recipient's care plan.

Subp. 40. **Primary caregiver.** "Primary caregiver" means the person designated by the individual as having the main role in providing informal care to the individual. Primary caregiver includes a family member, relative, friend, neighbor, and other person, who agrees to provide routine care and assistance to the recipient without reimbursement for the services and who cooperates with the case manager and other providers in assuring that services specified in the recipient's care plan are provided.

Subp. 41. **Provider.** "Provider" means a vendor who has an agreement or contract with the lead agency to provide a home and community–based service as specified in subpart 20.

Subp. 42. **Public health nurse.** "Public health nurse" means a registered nurse who meets the requirements of Minnesota Statutes, section 148.232, or the voluntary registration requirements established by the Minnesota Board of Nursing under Minnesota Statutes, section 148.171, paragraph (8).

Subp. 43. **Reassessment.** "Reassessment" means the interdisciplinary team's formal redetermination of a recipient's home and community–based service needs under part 9505.3545.

Subp. 44. **Recipient.** "Recipient" means an individual determined to be eligible to receive home and community–based services under a care plan that meets the requirements of part 9505.3520 and that is approved by the commissioner under part 9505.3680.

Subp. 45. **Registered nurse.** "Registered nurse" means a person licensed under and providing services within the scope of Minnesota Statutes, section 148.211.

Subp. 46. **Representative.** "Representative" means a person appointed by a court as a guardian or conservator under Minnesota Statutes, sections 252A.01 to 252A.21, or 525.539 to 525.6198; a parent of a child under age 21 unless the parent's parental rights have been terminated; or a spouse or other person authorized by the applicant or recipient as defined in part 9505.0015, subpart 8.

Subp. 47. **Respiratory therapist.** "Respiratory therapist" means a person who is a graduate of a program in respiratory therapy approved by the Council of Medical Education of the American Medical Association in collaboration with the American Respiratory Therapy Association. If the legislature acts to require certification, registration, or licensure of respiratory therapists, "respiratory therapist" means a person certified, registered, or licensed as a respiratory therapist by the state of Minnesota.

Subp. 48. **Respite care services.** "Respite care services" means temporary supervision, assistance, and care provided to a recipient as specified in part 9505.3580 to relieve the recipient's primary caregiver, or other informal caregiver.

Subp. 49. **Social worker.** "Social worker" means an individual who meets the minimum qualifications of a social worker under the Minnesota Merit System or a county civil service system in Minnesota and who is employed as a social worker by a county.

Subp. 50. **Speech therapist or speech–language pathologist.** "Speech therapist" or "speech–language pathologist" means a person holding a current certificate from the American Speech–Language–Hearing Association in evaluation and treatment of speech–language pathologies or who has completed the academic requirements and is acquiring the supervised work experience required for certification.

Subp. 51. **Transportation.** "Transportation" means transportation that is necessary because of the recipient's health service needs, that is indicated in the recipient's care plan or is approved by the recipient's case manager, and that is not eligible for medical assistance payment under parts 9505.0010 to 9505.0475.

Subp. 52. **Waiver.** "Waiver" means the document approved by the United States Department of Health and Human Services that allows the state to exclude parental or spousal income when determining an applicant's eligibility for medical assistance and to extend services under medical assistance as specified in parts 9505.3500 to 9505.3700. The term includes all amendments to the waiver, including any amendments after January 8, 1991, as approved by the United States Department of Health and Human Services.

Subp. 53. **Waiver year.** "Waiver year" means April 1 to March 31.

Subp. 54. **Working day.** "Working day" means the hours of a day, excluding Saturdays, Sundays, and holidays, when a lead agency is open for business.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3520 ELIGIBILITY FOR COMMUNITY ALTERNATIVE CARE SERVICES.

An individual is eligible for home and community–based services through CAC if the conditions in items A to I are met.

A. The individual is eligible for medical assistance as specified in part 9505.3640, subpart 1.

B. The individual is under 65 years of age.

C. The individual needs a home and community–based service which cannot be funded by sources other than CAC.

D. The individual has designated a primary caregiver who has been determined by a health care professional in coordination with the case manager to be capable of providing specific health services to the individual in the individual's residence and has expressed a willingness to provide the specific health services according to the individual's care plan.

E. The primary physician has certified that the individual would reside in a hospital or would require frequent hospitalization without home and community–based services.

F. The anticipated average monthly cost to the medical assistance program to implement the individual's care plan, determined on a twelve–month basis, must not exceed the cost to medical assistance of providing inpatient hospital services and physician services for the individual.

G. An individual who is eligible for inpatient hospital service financial coverage by a third–party payer and medical assistance is eligible for CAC services if the anticipated medical assistance payment for the CAC services is within the limit specified in item F. For purposes of this item, "third–party payer" refers to Medicare and a person, entity, agency, or government program as defined in part 9505.0015, subpart 46.

H. The cost to medical assistance of CAC services specified in the individual's care plan falls within the limit specified in the waiver for the aggregate annual cost of CAC services provided under the waiver for the waiver year in which the individual is a recipient.

I. The total number of recipients to be served, including the applicant if approved, falls within the limit specified in the waiver.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3530 REQUEST FOR CAC SERVICES.

Subpart 1. **Who may request service.** An individual or the representative of an individual who believes that the individual meets the criteria of part 9505.3520, items A to I may request participation in CAC according to parts 9505.3500 to 9505.3700. The request must be made to the department.

Subp. 2. **Response of department to request for CAC.** When the department receives a request for a determination of eligibility for CAC, the department shall determine which county will be the individual's county of financial responsibility and the estimated date or dates for the start of the individual's home and community–based services. The department shall designate an acting case manager and send the acting case manager the forms necessary to obtain the information required under part 9505.3540. The forms must be sent no later than five working days after receiving the request. If the acting case manager is not employed by the local agency of the applicant's county of service, the department shall notify the local agency about the request to participate in CAC and the designation of an acting case manager.

Subp. 3. **Local agency designation of team members.** No later than five working days after receiving the department's notice, the local agency of the applicant's county of service must designate a social worker and public health nurse to serve on the interdisciplinary team required under part 9505.3535.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3535 INTERDISCIPLINARY TEAMS; ESTABLISHMENT AND MEMBERSHIP.

Subpart 1. **Applicant's interdisciplinary team.** No later than ten working days after being designated as an applicant's acting case manager, the acting case manager must form an interdisciplinary team. The acting case manager shall consult the applicant or, when it is appropriate, the applicant's representative in forming the team. The team must consist of at least the persons specified in items A to K:

A. the applicant or, when it is appropriate, the applicant's representative;

B. the acting case manager;

C. the applicant's physician;

D. the applicant's primary nurse;

E. in the case of an applicant who is an inpatient, a medical social worker designated by the hospital to assist in discharge planning for the applicant;

F. the social worker designated under part 9505.3530, subpart 3;

G. the county public health nurse designated under part 9505.3530, subpart 3;

H. a representative of Services for Children with Handicaps if the applicant is under 21 years of age;

I. when it is appropriate, other persons who are expected to be the applicant's informal caregivers;

J. a representative of the local school district if the applicant is under 22 years of age; and

K. other health care professionals providing services required by the applicant's medical condition, consistent with part 9505.0190 and Code of Federal Regulations, title 42, section 431.51.

Subp. 2. **Interdisciplinary team; reconvened.** The case manager must reconvene the interdisciplinary team established under subpart 1 when a reassessment is required to determine a recipient's continued eligibility for CAC. If possible, the case manager shall assure continuity of service of team members. At a minimum, the reconvened team must include the persons specified in items A to I:

A. the recipient or, when it is appropriate, the recipient's representative;

B. the case manager;

C. the recipient's primary caregiver;

D. the recipient's physician;

E. the social worker designated under part 9505.3530, subpart 3;

F. the county public health nurse designated under part 9505.3530, subpart 3;

G. a representative of Services for Children with Handicaps if the recipient is under 21 years of age;

H. a representative of the local school district if the recipient is under 22 years of age; and

I. other health care professionals providing services required by the recipient's medical condition, consistent with part 9505.0190 and Code of Federal Regulations, title 42, section 431.51.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3540 INTERDISCIPLINARY TEAM RESPONSIBILITIES; ASSESSMENT.

Subpart 1. **Assessment of applicant's service needs.** The team must assess the home and community–based services that an applicant will need to live in the community. The assessment must be completed on forms provided by the commissioner.

Subp. 2. **Assessment of financial resources.** The team must assess an applicant's financial resources to identify third–party payers and other financial resources as defined in part 9505.0015, subpart 46, using forms provided by the commissioner.

Subp. 3. **Assessment of the applicant's home.** The team must assess the home in which the applicant lives or will live to determine if the applicant's health and safety can be assured in the residence. This assessment must be completed on forms provided by the commissioner. The assessment shall include a determination of the need for environmental modifications in the home as specified in part 9505.3610.

Subp. 4. **Assessment of person to be primary caregiver.** The team must assess the willingness and ability of the person who is expected to be the CAC applicant's primary caregiver. The team must report its assessment under this subpart on the form provided by the commissioner.

Subp. 5. **Authorization to release information.** The team must ask the applicant or the applicant's representative to sign forms that authorize the release of the applicant's medical records to the team for the assessment. A separate form provided by the commissioner must be completed and signed for each authorization of release of information. The period of the authorization must not exceed one year. The following information must be on the form before the applicant's signature or, when it is appropriate, the signature of the applicant's representative:

A. the applicant's name;

B. the date of the authorization;

C. the information authorized;

D. the person authorized to give the information;

E. the person to whom the information is to be given;

F. a description of how the information will be used during the assessment to determine the appropriateness of CAC services; and

G. the date the authorization expires.

Subp. 6. **Rights, appeals, and freedom to choose.** The team must give the applicant or the applicant's representative written information about the applicant's rights under CAC including:

A. the right to appeal the assessment;

B. the right to choose among qualified providers of home and community–based services, consistent with part 9505.0190 and Code of Federal Regulations, title 42, section 431.51;

C. the right to confidentiality; and

D. the right to accept or reject a recommendation of the team to use home and community–based services rather than reside in a hospital.

The acting case manager must document compliance with this subpart by signing and submitting to the department forms provided by the commissioner that state the required information was given to the applicant or, when it is appropriate, the applicant's representative.

Subp. 7. **Development of a care plan.** The interdisciplinary team shall develop a care plan for the applicant that is based on the information obtained in subparts 1 to 5. The plan must meet the requirements of subpart 8. The acting case manager must notify the department and estimate the additional time needed if the time required to complete the care plan and assessments required under this subpart exceeds the time specified in part 9505.0090, subpart 2. The applicant's care plan must be signed by the applicant or, when it is appropriate, the applicant's representative, the applicant's physician, and the acting case manager.

Subp. 8. **Contents.** The care plan developed by the interdisciplinary team for an applicant or recipient must contain at least the information specified in items A to D. The plan must be on forms provided by the commissioner. The care plan must include all health services approved by the individual's physician regardless of the funding source or sources available to pay the cost of the health services.

A. The recommendation of the team that the applicant be approved for services funded by CAC because the applicant meets the eligibility criteria under part 9505.3520 or, in the case of a recipient, continues to be approved for services funded by CAC because the applicant continues to meet the eligibility criteria under part 9505.3520.

B. A description of the health services necessary to maintain the individual in the community, including:

(1) home and community–based services needed by the individual;

(2) qualified providers of the home and community–based services selected by the applicant or, when it is appropriate, the applicant's representative or, in the case of a recipient, by the recipient or, when it is appropriate, the recipient's representative to meet the needs identified in subitem (1);

(3) the informal caregivers who are willing and able to provide services identified in subitem (1);

(4) the required frequency of the services;

(5) the anticipated date or dates on which the applicant's services must be started;

(6) the provisions for back–up services if there is an emergency;

(7) the cost of each service;

(8) the funding source for each service; and

(9) an estimate of the total cost of all health services in the care plan including home and community–based services.

C. Documentation that the team allowed the applicant or recipient or, when it is appropriate, the representative of the applicant or recipient to choose among the available qualified providers.

D. Documentation that the applicant or recipient or, when it is appropriate, the representative of the applicant or recipient, the acting case manager or case manager, and the physician of the applicant or recipient approve the home care plan.

Subp. 9. **Team recommendation.** After completing the assessments required in subparts 1 to 4 and the care plan required in subpart 8, the interdisciplinary team must recommend one of the following:

A. that the applicant remain a hospital inpatient;

B. that the applicant be admitted to a facility from the applicant's home. For purposes of this item, "facility" means a hospital as defined in part 9505.0175, subpart 16, or a long–term care facility as defined in part 9505.0175, subpart 23; or

C. that the applicant receive health services including home and community–based services in the community.

The team's recommendation must be supported by the assessments conducted under subparts 1 to 4 and the services specified in the applicant's care plan. The applicant's physician, the acting case manager or case manager and the applicant or, when it is appropriate, the applicant's representative must sign the application.

Subp. 10. **Transmittal of plan, assessments, and recommendations to the commissioner.** The team must submit the following documents to the commissioner for a determination of the applicant's eligibility for CAC services:

A. the completed assessments required under subparts 1 to 4;

B. the documentation required under subpart 6;

C. the request for CAC services, signed by the applicant or the applicant's representative;

D. the recommendation required under subpart 9; and

E. the care plan signed by the physician, case manager, and the applicant or the applicant's representative.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3545 REASSESSMENT BY INTERDISCIPLINARY TEAM.

Subpart 1. **Reassessment required.** A recipient's need and eligibility for home and community–based services must be reassessed at least once every six months. The reassessment must be carried out by an interdisciplinary team convened by the recipient's case manager as specified in part 9505.3535, subpart 2. At a minimum, the reassessment shall include the items specified in part 9505.3540, subparts 1 and 3 to 9. The team must review and modify the recipient's care plan as necessary and appropriate to meet the recipient's needs.

Subp. 2. **Responsibility to assure reassessment.** A local agency is responsible to assure that a recipient's reassessment is completed as required under subpart 1. If the reassessment is not completed, the local agency shall be responsible for paying the costs of the services specified in the recipient's care plan and received by the recipient until the reassessment is completed and submitted to the department.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3550 RECIPIENT'S TERMINATION FROM CAC.

A recipient shall be terminated from eligibility for CAC services when:

A. the recipient chooses not to use CAC services;

B. the recipient no longer needs CAC services as determined by a reassessment;

C. the recipient's condition requires continued hospitalization for an indefinite period as certified by the recipient's physician;

D. the recipient who has been hospitalized more than 30 consecutive days in a waiver year requires home and community–based services that are not available in the community;

E. the recipient is no longer eligible for medical assistance;

F. the recipient has third–party payer coverage that pays the cost of inpatient hospital services to the extent CAC services are no longer cost–effective; or

G. the recipient's condition requires health services having a cost to medical assistance that is greater than the medical assistance cost of inpatient hospital services to the recipient.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3560 CASE MANAGEMENT SERVICES.

Subpart 1. **Required service.** Case management services must be provided to a recipient. The lead agency shall be responsible for implementing the case management services required under parts 9505.3500 to 9505.3700.

Subp. 2. **Designation of case manager.** No later than five working days after receiving the department's notice that an applicant's request for CAC services has been approved, the lead agency must consult with the applicant or the applicant's representative and designate a case manager. The case manager must not have a financial interest in the services provided to the applicant other than the case manager's employment by the lead agency.

Subp. 3. **Case manager responsibilities.** The case manager or, when it is appropriate, the acting case manager must:

A. convene and coordinate the interdisciplinary team;

B. gather information needed to determine an individual's eligibility for CAC under parts 9505.3500 to 9505.3700;

C. inform applicants, recipients, and their representatives about the rights specified in part 9505.3540, subpart 6 and CAC services;

D. complete and submit forms required by the commissioner under parts 9505.3500 to 9505.3700;

E. locate resources that are available to provide the services specified in the recipient's care plan;

F. coordinate and arrange services specified in the recipient's care plan;

G. seek out other home and community–based services that may contribute to the recipient's quality of life while the recipient is residing in the community but that are not reimbursable under medical assistance or CAC. Examples of other services include legal, recreational, educational, vocational, and social services;

H. meet with the recipient or the recipient's representative in the recipient's home as necessary to assure the recipient's safety and welfare and assure implementation of the recipient's services as specified in the recipient's care plan;

I. revise the care plan if the recipient's needs change between scheduled reassessments and, when it is appropriate, obtain the approval of the recipient's physician;

J. monitor costs of services to assure that the cost of the services specified in the care plan does not exceed the approved estimated cost of the care plan;

K. investigate whether the costs of the services specified in the applicant's or recipient's care plan can be met by a third–party payer other than medical assistance or CAC. The case manager must document the investigation on the applicant's or recipient's care plan;

L. reconvene the interdisciplinary team at least every six months as required under part 9505.3545 or more often if necessary because of changes in the recipient's health or social needs;

M. participate in the recipient's reassessment as required under part 9505.3545 and submit the reassessment form to the department no later than ten working days after the reassessment is completed;

N. submit the care plan and revisions of the care plan to the commissioner for approval;

O. send to the department the information needed to carry out responsibilities under part 9505.3680, subparts 1 and 2;

P. give notice of acceptance or rejection of an application or reduction, denial, or termination of benefits; and

Q. request the applicant, recipient, or the representative of the applicant or recipient, and the individual's physician to approve and sign the individual's care plan.

The information required in items N, O, and Q must be provided on forms provided by the commissioner. An applicant or recipient is ineligible for CAC services if the applicant or recipient or, when it is appropriate, the applicant's or recipient's representative fails to sign the care plan. The acting case manager of an applicant or the case manager of a recipient must explain to the person whose signature is being requested the consequences of failing to sign.

Subp. 4. **Case manager reports about suspected abuse of a vulnerable adult.** A case manager who has reason to believe a recipient is or has been subject to abuse or neglect as defined in Minnesota Statutes, section 626.557, subdivision 2, that occurs at the recipient's residence or a place where the recipient receives CAC services shall immediately comply with the reporting and other actions required under Minnesota Statutes, section 626.557. The case manager shall cooperate with the responsible county authority to assure the recipient's health and safety during the investigation. The case manager must request a report from the responsible county authority in order to take the action required in subpart 6.

Subp. 5. **Case manager reports about suspected abuse of a child.** A case manager who has reason to believe a recipient who is a child is or has been subject to abuse or neglect as defined in Minnesota Statutes, section 626.556 shall immediately report the circumstances of alleged abuse or neglect to the county authority responsible for assuring the protection of children. The case manager shall cooperate with the responsible county authority to assure the recipient's health and safety during the investigation. The case manager must request a report from the responsible county authority in order to take the action required in subpart 6.

Subp. 6. **Other actions required of case manager.** When the case manager receives the findings of the investigation carried out under subpart 4 or 5, the case manager shall determine whether a reassessment of the recipient according to part 9505.3545 is needed to amend the recipient's care plan. The case manager shall take other actions as needed to assure the recipient's health and safety, such as (1) arranging for the services of another CAC provider, (2) working out another living arrangement for the recipient, or (3) withdrawing the CAC service or services. The case manager shall forward the amended care plan to the commissioner for approval.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3570 HOME HEALTH SERVICES.

Home health services established under parts 9505.0170 to 9505.0475 are available to a recipient except that the limits placed on the amount, duration, and scope of the services eligible for medical assistance payment shall be as specified in the recipient's plan of care.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3575 HOMEMAKER SERVICES.

Subpart 1. **Eligibility for service.** Homemaker services are available under CAC if necessary to enable a recipient to remain in the community.

Subp. 2. **Homemaker services provider; lead agency or contractor.** The lead agency may provide directly or may contract for homemaker services that are specified in the recipient's care plan. If the lead agency directly provides homemaker services, the lead agency must also provide supervision of the homemaker's activities. If the lead agency contracts with a provider for homemaker services, the provider must meet the requirements of Minnesota Statutes, sections 144A.43 to 144A.46.

Subp. 3. **Homemaker service standards.** The lead agency shall assure that homemaker services to a recipient are provided by the homemaker according to parts 9565.1000 to 9565.1300 and the recipient's care plan.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3580 RESPITE CARE SERVICES.

Subpart 1. **Eligibility for service.** Respite care services are available under CAC if the service is necessary to maintain the recipient during a time when the primary caregiver is unable to care for the recipient. Respite care services to a recipient are limited to 720 hours per waiver year.

Subp. 2. **Provider standards.** Respite care may be provided in an out–of–home setting as specified in item A or in the recipient's home as specified in item B.

A. Out–of–home respite care must be provided in a facility approved by the lead agency such as a hospital, nursing home, foster home, or community residential facility. When out–of–home respite care is provided, the facility must be one that meets state licensure standards.

B. A registered nurse or a public health nurse may give respite care in the recipient's home. The person providing respite care services must act in the place of the primary caregiver and shall be available to the recipient throughout the absence of the primary caregiver.

Subp. 3. **Contract required.** The lead agency shall contract with each person, facility, agency, or entity that provides respite care services. If the respite care is provided in the recipient's home, the contract must require the service to be provided as specified in subpart 2, item B. Additionally, the contract must include the authority of the person providing the respite care to act in the event of an emergency affecting the recipient or the recipient's home or must include the name of the person designated by the primary caregiver to act on behalf of the primary caregiver in the event of such an emergency. The lead agency shall monitor the contractor's compliance with the terms of the contract.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3585 PHYSICIAN SERVICES.

Physician services as specified in part 9505.0345 to a CAC recipient may include home visits as necessary to maintain the recipient's safe care in the community.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3600 COUNSELING AND TRAINING SERVICES.

Subpart 1. **Eligibility to receive counseling and training services.** Counseling and training services are available under CAC and shall be provided to a recipient, primary caregiver, and to members of the recipient's family with whom the recipient lives or who routinely care for the recipient. For purposes of this part, "member of the recipient's family" or "family member" refers to the recipient's parent, spouse, children, friends, relatives, foster family, or relatives–in–law. The term does not include individuals who are employed to care for the recipient.

Subp. 2. **Purpose of training.** The training must be for the purpose of increasing the ability of a primary caregiver or a member of the recipient's family to maintain and care for the recipient at home. It shall include the use of equipment and treatment regimens as specified in the recipient's care plan and training updates as may be necessary to safely maintain the recipient at home.

Subp. 3. **Purpose of counseling.** Counseling under CAC must be designed to help the recipient, the primary caregiver, and the recipient's family members handle crises related to the recipient's condition, develop coping strategies related to the recipient's daily care, and reduce stress.

Subp. 4. **Case manager approval required.** Counseling and training services under CAC must be approved by the case manager and must be specified in the recipient's care plan.

Subp. 5. **Eligibility to provide counseling and training.** A person providing counseling and training services to a recipient, a primary caregiver, or a recipient's family member must be the recipient's physician, a registered nurse, a public health nurse, a social worker, or a medical social worker, or other qualified person as specified in the recipient's care plan and

approved by the case manager. The person providing training service must determine and must document in the recipient's care plan whether a person being trained as the primary caregiver is competent to provide the services required to maintain the recipient at home.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3610 ENVIRONMENTAL MODIFICATIONS IN THE HOME.

Subpart 1. **Eligibility for service.** An environmental modification in the home of a recipient is available under CAC if the modification is:

A. necessary to avoid the recipient's hospitalization;

B. approved and authorized by the recipient's case manager;

C. specified in the recipient's care plan; and

D. not available from another funding source. Examples of other funding sources are Services for Children with Handicaps and the Minnesota Housing Finance Agency.

Subp. 2. **Provider standards.** An environmental modification to the home must be completed according to all applicable state and city building codes by a provider who has been approved by the case manager. The lead agency shall specify the terms of the service to be provided in a contract or service agreement between the agency and the provider approved by the case manager. The lead agency must assure that the environmental modification in the home, when completed, meets the terms specified in the contract or service agreement between the lead agency and the provider.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3620 MEDICAL EQUIPMENT.

Subpart 1. **Eligibility for medical equipment and supplies.** Medical equipment and supplies that are generally available to an individual in an institution are available under CAC for home use if:

A. the medical equipment and supplies are specified in the recipient's plan of care;

B. CAC is the only funding source available to the recipient in regard to the medical equipment and supplies; and

C. the medical equipment and supplies meet the requirements of part 9505.0310 in regard to rental, purchase, and safeguarding of recipient care.

Subp. 2. **Prior approval required.** Medical equipment and supplies require prior approval of the commissioner if:

A. they are not in the recipient's care plan approved by the commissioner under part 9505.3550;

B. they are medically necessary;

C. they exceed $25 in value per month; and

D. CAC is the only funding source for the medical equipment and supplies.

The case manager must submit to the commissioner an addendum to the recipient's care plan that documents compliance with this subpart. The commissioner shall determine whether the medical equipment and supplies meet the requirements of parts 9505.3500 to 9505.3700.

Subp. 3. **Exemption from limitation on type of equipment and supplies available.** The limitations on the types of equipment or supplies set in part 9505.0310, subpart 1, item A, and subpart 4, item A, do not apply to durable medical equipment and supplies available under CAC.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3622 MEDICAL TRANSPORTATION.

Transportation of a recipient for medical purposes is available under CAC if the transportation is specified in the recipient's care plan to provide access to a medically necessary

service and if the transportation lies outside the scope of the local agency's procedure to assure access as required under part 9505.0140, subpart 2.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3624 PRESCRIBED DRUGS.

Subpart 1. **Eligibility for service.** Prescribed drugs are available under CAC if the drug is authorized by the recipient's physician, is specified in the recipient's care plan, and would be available under medical assistance to the recipient as an inpatient, as provided by Minnesota Statutes, section 256B.0625, subdivision 13.

Subp. 2. **Number of prescribed drugs available to recipient.** The availability of prescribed drugs under CAC is subject to the limitations under part 9505.0340. However, the number of different prescribed drugs that a recipient may fill or refill per month is not limited.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3626 OTHER PROFESSIONAL SERVICES; THERAPY.

Subpart 1. **Eligibility for other professional services; therapies available as medical assistance services.** A recipient is eligible for a therapy that is available to medical assistance recipients under part 9500.1070. The therapy must be provided by a physical therapist, occupational therapist, speech–language pathologist, or respiratory therapist. The therapy provided to the recipient must comply with the provider standards set in parts 9500.1070 and 9505.3500 to 9505.3700.

Subp. 2. **Eligibility for other professional services; nutritional therapy.** Nutritional therapy is available under CAC. The therapy must be provided by a nutritionist.

Subp. 3. **Service limitations.** The amount, duration, and scope of therapy provided to a recipient by a physical therapist, occupational therapist, speech–language pathologist, respiratory therapist, or nutritionist must be ordered by the recipient's physician and specified in the recipient's care plan.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3630 FOSTER CARE.

Subpart 1. **Eligibility for payment.** Foster care services to a recipient are available under CAC if the services provide ongoing residential and support services which exceed the scope of the services provided through Title IV–E or the Minnesota Supplemental Aid Program. Payment does not include room and board. For purposes of this part, "Title IV–E" means the federal program established by the Social Security Act that reimburses administrative and training costs incurred in providing services under United States Code, title 42, sections 470 to 479 and 670 to 679. "Minnesota Supplemental Aid Program" means the program established in Minnesota Statutes, section 256D.37.

Subp. 2. **Provider standards.** A provider of foster care services must comply with a standard specified in item A or B.

A. A provider of foster care services to a recipient under 18 years of age must be licensed according to parts 9545.0010 to 9545.0260.

B. A provider of foster care services to a recipient who is at least 18 years of age must be licensed according to parts 9555.5105 to 9555.6265.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3635 EXCLUDED SERVICES.

The following services in items A to F are not available under CAC:

A. room and board except for respite care provided outside of the recipient's residence;

B. respite care for a recipient of foster care provided under CAC if the payment agreement with the foster care provider includes the payment amount for the respite care to be purchased by the foster care provider;

C. health services for which other funding sources are available;

D. a CAC service to an individual who is not a recipient;

E. a CAC service that is not specified in the recipient's care plan as approved by the commissioner or, in the case of medical transportation under part 9505.3622, the approval of the recipient's case manager; and

F. a CAC service for a purpose other than respite care while a recipient is an inpatient as defined in part 9505.0175, subpart 17.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3640 LOCAL AGENCY RESPONSIBILITIES.

Subpart 1. **Determination of applicant's eligibility for medical assistance.** A local agency must determine a CAC applicant's eligibility for medical assistance and must redetermine a recipient's eligibility for medical assistance. The determination and redetermination shall be as specified in parts 9505.0010 to 9505.0150, except that the provisions of part 9505.0075 relating to the availability of parental or spousal income and assets shall not apply. Although the local agency making the determination must be the local agency of the applicant's or recipient's county of financial responsibility, the local agency obtaining the information required under parts 9505.0010 to 9505.0150 may be the local agency in the county of service.

Subp. 2. **Designation of lead agency.** A local agency that is the county of service for a CAC applicant or recipient must designate a lead agency to administer the county's community alternative care program. The designated lead agency may be in the recipient's county of residence or service if different from the county of financial responsibility.

Subp. 3. **Calculation of parental or spousal contribution.** The financial contribution of a parent or spouse shall be determined according to Minnesota Statutes, sections 256B.14 and 252.27, and appropriate rules adopted under those statutes. The refusal or failure of a recipient's obligated parent or spouse to pay the contribution does not affect the recipient's eligibility for medical assistance and CAC.

If the department or the local agency finds that the obligated parent or spouse refused or failed to pay the determined contribution, a cause of action against the obligated parent or spouse may be initiated as authorized in Minnesota Statutes, sections 252.27 and 256B.14.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3645 LEAD AGENCY RESPONSIBILITIES.

Subpart 1. **Enrollment as CAC provider.** A lead agency must enroll under part 9505.0195 as a provider of CAC services.

Subp. 2. **Compliance with rules and local agency requirements.** A lead agency must comply with the requirements of parts 9505.3500 to 9505.3700 and the local agency that made the designation under part 9505.3640, subdivision 2.

Subp. 3. **Administrative functions.** A lead agency is responsible to perform the following functions in regard to CAC services to a recipient:

A. establish agreements and contracts to provide the recipient's CAC services as in part 9505.3650, subpart 2;

B. review CAC provider billings for approval for payment according to the provider's contract, purchase agreement, or service agreement with the lead agency;

C. furnish billings for CAC services according to the procedures of part 9505.0450;

D. ensure that the projected cost to medical assistance for the services specified in the recipient's care plan does not exceed the cost to medical assistance if the recipient resided in a hospital;

E. make available to the commissioner records of funds expended for CAC services; and

F. maintain and make available to the commissioner records of health services provided to recipients.

Subp. 4. **Services to recipient.** A lead agency must assure that necessary safeguards are taken to protect the health and welfare of a recipient. For this purpose, the lead agency must:

A. require CAC services to be provided as specified in parts 9505.3500 to 9505.3700, either directly or through a contract or purchase of service agreement as specified in part 9505.3650;

B. assure a CAC service, other than respite care, is not provided to a recipient while the recipient is an inpatient as defined in part 9505.0175, subpart 17; and

C. monitor providers of CAC services using the criteria in part 9505.3650.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3650 PROVIDERS OF CAC SERVICES.

Subpart 1. **Criteria for selecting a CAC provider.** A provider of home and community–based services under CAC must meet the criteria in items A to C.

A. The provider must be employed by the county or have agreed as specified in subpart 2 to provide home and community–based services under CAC.

B. The provider must meet all licensure requirements and professional standards applicable to the service or services being provided as specified in parts 9505.3500 to 9505.3700.

C. The provider must not be a primary caregiver or responsible relative of the recipient to whom the provider is furnishing the home and community–based service.

Subp. 2. **Agreement to provide CAC services.** A lead agency may provide a CAC service directly or indirectly. If the lead agency chooses to provide the CAC service indirectly, the agency must have a contract, purchase agreement, or service agreement with the CAC service provider that specified the information in items A to I:

A. the beginning and ending dates of the contract or agreement;

B. the duties and responsibilities of the provider including compliance with applicable certifications, licensures, standards, and supervision of employees as required under parts 9505.3500 to 9505.3700;

C. the person or persons to be served as specified in the recipient's care plan;

D. an agreement to provide the service according to the amount, frequency, and scope specified in the care plan of the person being served;

E. the payment amount to be received for the service and the provider's agreement to accept this amount as payment in full;

F. the reports and records to be kept by the provider and given to the lead agency;

G. the provider's agreement to comply with the Minnesota Government Data Practices Act;

H. the provider's documentation of an individual abuse prevention plan that complies with parts 9555.8000 to 9555.8500; and

I. the conditions under which the lead agency shall terminate the provider's contract or agreement.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3660 CAC PROVIDER RECORDS.

The lead agency and a CAC provider under contract with the lead agency must maintain for at least five years complete program and fiscal records and supporting documentation identifying the recipients served, the services provided, and the costs incurred. The records must be identified and maintained separately from other provider records. The lead agency's and the provider's records are subject to the maintenance schedule, audit availability requirements, and other provisions in parts 9505.2160 to 9505.2245.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3670 RATES FOR CAC SERVICES.

Subpart 1. **Maximum CAC service rate.** Unless otherwise specified by the legislature, the commissioner shall annually set the maximum rate that is available to a county as reimbursement to a provider for a CAC service. The rates for CAC services must be consistent with medical assistance rates for comparable services. Annually on July 1 after January 8, 1991, the commissioner shall authorize an increase in the CAC service rates available to a county as reimbursement to a CAC provider up to the percentage change forecast by the Home Health Agency Market Basket. The Home Health Agency Market Basket is published by Data Resources and is subject to quarterly revision. The Home Health Agency Market Basket is incorporated by reference and is available through the Minitex interlibrary loan system.

Subp. 2. **Notice to counties.** By June 1 of each year, the commissioner shall notify a lead agency of the statewide maximum rate allowed for payment of providing CAC services under subpart 1. Additionally, the commissioner shall notify the counties in writing of the percentage increase allowed under subpart 1.

Subp. 3. **County CAC service rate.** A county may set rates for CAC services not to exceed the rates established in subpart 1. Under no circumstances is the department responsible for payment of rates higher than those established under subpart 1 and any amounts paid in excess of those rates shall be recoverable by the commissioner. County rates are subject to audit by the commissioner.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3680 DEPARTMENT RESPONSIBILITIES.

Subpart 1. **Review and approval of CAC applications.** The commissioner must review and approve or deny each request for eligibility for the community alternative care program according to the criteria of part 9505.3520. The commissioner must determine whether the applicant is eligible for home and community–based services under CAC. No later than 15 working days after receiving the information required under part 9505.3540 to determine the applicant's eligibility for CAC, the commissioner must notify the acting case manager and the lead agency of its determination or of the additional information needed to make the determination.

Subp. 2. **Review of care plan and eligibility reassessments.** The commissioner must approve or deny care plan and eligibility reassessment recommendations according to the criteria of part 9505.3520. The recipient's preexisting care plan shall remain in effect pending the commissioner's approval or denial of the reassessment recommendation.

Subp. 3. **Records.** The department must maintain records related to the community alternative care program for a period of at least five years.

Subp. 4. **Monitor program expenses.** The department must monitor CAC expenditures to assure that the expenditures do not exceed the approved waiver limits for the home and community–based services under CAC.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3690 BILLING FOR CAC SERVICES.

A CAC provider must submit a claim for payment for a CAC service specified in a recipient's care plan in the manner specified by the commissioner. A claim under this part must not exceed the amount specified in the contract, purchase agreement, or service agreement between the CAC provider and the lead agency. The CAC provider must submit the claim for payment according to the billing procedures in part 9505.0450. However, the claim shall not be submitted directly to the department.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

9505.3700 APPEALS.

Subpart 1. **Appealable actions.** An applicant assessed under part 9505.3540 or a recipient reassessed under part 9505.3545 may appeal if one of the following actions is taken by the department or the local or lead agency:

A. a CAC service is denied;

B. eligibility for CAC services is not determined with reasonable promptness; or

C. a recipient's CAC services are reduced, suspended, or terminated.

Subp. 2. **Actions that are not appealable.** A denial, reduction, suspension, or termination of CAC services is not an appealable action if one of the following conditions applies:

A. the cost of the applicant's or recipient's home and community–based care exceeds the cost of hospital care;

B. the waiver aggregate average cost would be exceeded;

C. there are no openings available in the program; or

D. the case manager withdraws the CAC service or services as provided under part 9505.3560, subpart 6.

Subp. 3. **Notice of right to appeal.** An applicant assessed under part 9505.3540 or a recipient reassessed under part 9505.3545 has the right to appeal an action described in subpart 1. At the time a requested service is denied, reduced, suspended, or terminated by the case manager, lead agency, or department, the case manager must review with and provide the individual written notice about the proposed action and about the right to appeal. The notice must state the reasons for an appealable action, and an explanation of the right to appeal and how to appeal. The notice must also state that the recipient's ongoing CAC services will not be reduced, suspended, or terminated if the appeal is filed before the date specified in the notice, unless the recipient requests in writing not to receive CAC services while the appeal is pending.

Subp. 4. **Submission of appeals.** An applicant assessed under part 9505.3540 or a recipient reassessed under part 9505.3545 who wants to appeal must submit the appeal in writing to the local agency of the county of service or to the department. The appeal must be received by the department no later than 30 days after the recipient is made aware of the action taken in subpart 1 or no later than 90 days after the recipient is made aware of the action taken in subpart 1 if good cause reason for delay can be shown.

Subp. 5. **Appeal of action.** An appeal of issues meeting the criteria under subparts 1 and 2 shall be heard and decided according to Minnesota Statutes, section 256.045.

Subp. 6. **Continuation of services pending an appeal.** If a recipient appeals a denial, reduction, suspension, or termination of CAC services that the recipient has been receiving on an ongoing basis and that are part of the recipient's care plan approved by the recipient's physician, the lead agency must continue to provide the ongoing CAC services at the level specified in the recipient's care plan until a decision on the appeal is recommended by the department's referee and adopted by the commissioner. Nothing in parts 9505.3500 to 9505.3700 shall prohibit the department from seeking reimbursement from the recipient for the costs of providing CAC services pending a decision on an appeal if the order adopted by the commissioner is adverse to the recipient.

Statutory Authority: *MS s 256B.49*

History: *15 SR 1513*

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; parts 9500.1070, subparts 1, 4, 6, 12 to 15, and 23; 9505.0170 to 9505.0475; 9505.0500 to 9505.0540; 9505.1000 to 9505.1040; and 9505.2160 to 9505.2245, and with rules adopted by the commissioner under Minnesota Statutes, sections 256.991 and 256D.03, subdivision 7, paragraph (b).

Statutory Authority: *MS s 256.991; 256D.03 subd 7 para (b)*

History: *10 SR 842; 13 SR 1688*

9505.5005 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9505.5000 to 9505.5105 have the meanings given them in this part.

Subp. 1a. **Authorization number.** "Authorization number" means the number issued by the medical review agent that establishes that the surgical procedure requiring a second surgical opinion is medically appropriate.

Subp. 1b. **Certification number.** "Certification number" means the number issued by the medical review agent that establishes that all or part of a recipient's inpatient hospital services are medically necessary.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or an authorized designee.

Subp. 3. **Consultant.** "Consultant" means an individual who is licensed or registered according to state law or meets the credentials established by the respective professional organization in an area of health care or medical service; is employed by or under contract with the Department of Human Services; advises the department whether to approve, deny, or modify 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. 12a. **Medical appropriateness or medically appropriate.** "Medical appropriateness" or "medically appropriate" refers to a determination, by a medical review agent or the department, that the recipient's need for a surgical procedure requiring a second surgical opinion meets the criteria in part 9505.0540 or that a second or third surgical opinion has substantiated the need for the procedure.

Subp. 12b. **Medical review agent.** "Medical review agent" means the representative of the department who is authorized in parts 9505.0500 to 9505.0540 to determine the medical appropriateness of procedures requiring second surgical opinions.

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. 18a. **Second opinion or second surgical opinion.** "Second opinion" or "second surgical opinion" means the determination by the medical review agent under part 9505.5050, subpart 1, or by a second physician under part 9505.5050, subpart 2, that a surgical procedure requiring a second surgical opinion is or is not medically appropriate.

Subp. 18b. **Third opinion or third surgical opinion.** "Third opinion" or "third surgical opinion" means the determination by a third physician under part 9505.5050, subpart 3, that a surgical procedure requiring a second surgical opinion is or is not medically appropriate.

Subp. 19. **Working days.** "Working days" means Monday through Friday, excluding state recognized legal holidays.

Statutory Authority: *MS s 256.991; 256D.03 subd 7 para (b)*

History: *10 SR 842; 13 SR 1688*

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 9505.0170 to 9505.0475 and 9505.5025; and Minnesota Statutes, section 256B.0625, subdivision 25. 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; 256D.03*

History: *10 SR 842; 13 SR 1688; 16 SR 2102*

9505.5015 AFTER THE FACT 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. The provider of the health service shall submit the request on form DHS–1856 or DHS–1855 as required in part 9505.5010, subpart 3, and shall submit materials, reports, progress notes, admission histories, or other information that substantiates that the service was necessary to treat the recipient.

Subp. 2. **Emergencies.** A health service requiring prior authorization shall retroactively receive authorization in an emergency if the provider submits the request for authorization after providing the initial service and the provider documents the emergency. Billing for emergency services must comply with part 9505.0450.

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 180 days of the date the case was opened.

Subp. 4. **Third party liability.** A provider of a health service originally billed to Medicare or a third–party payer as defined in part 9505.0015, subpart 46, for which Medicare or the third–party payer denied payment or made a partial payment may retroactively submit a request for authorization if the provider wants to receive payment of the difference between the medical assistance or general assistance medical care payment rate for the service and the payment by the third–party payer. The service is eligible for medical assistance or general assistance medical care reimbursement if it meets the criteria in part 9505.5030 and if the authorization request is submitted to the department along with a copy of the notice explaining the denial or partial payment within 180 days of the date of the notice.

Subp. 5. **Authorization of dental prostheses.** A dental services provider who wants to obtain after the fact authorization of a removable dental prosthesis for which authorization is required under part 9505.0270, subpart 4, must submit the request on form DHS–1856 before submitting an invoice for the removable prosthesis. To obtain after the fact authorization, the removable prosthesis must meet a criterion specified in part 9505.0270, subpart 4, items A to C.

Subp. 6. **Authorization of medical supplies or equipment for recipient being discharged from hospital or long–term care facility.** Medical supplies or equipment requiring prior authorization under part 9505.0310, subpart 3, or Minnesota Statutes, section 256B.0625, subdivision 25, shall receive after the fact authorization in the case of a recipient being discharged from a hospital or long–term care facility if:

A. the provider submits a request for authorization after providing the initial service;

B. the provider documents the date of the recipient's discharge from the long-term care facility or hospital;

C. the recipient's discharge plan specifies the medical supplies or equipment as medically necessary and appropriate for the recipient's home care; and

D. the medical supplies and equipment are eligible for medical assistance payment under part 9505.0310.

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

History: *10 SR 842; 13 SR 1688; 16 SR 2102*

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 and outpatient elective surgical procedures according to the list published in the State Register under Minnesota Statutes, section 256B.0625, subdivisions 1 and 4. Publication shall occur in the last issue of the State Register for the month of October if there has been a revision in the list since the last October. In addition, the department shall publish any revision of the list at least 45 days before the effective date if the revision imposes a second 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; 256D.03 subd 7 para (b)*

History: *10 SR 842; L 1988 c 689 art 2 s 268; 13 SR 1688*

9505.5040 EXEMPTIONS TO SECOND SURGICAL OPINION REQUIREMENTS.

If the requirements of part 9505.5096 are met and the surgical procedure is medically appropriate as defined in part 9505.5005, subpart 12a, a second surgical opinion is not required in the circumstances set out in items A to F:

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; 256D.03 subd 7 para (b)*

History: *10 SR 842; 13 SR 1688*

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 SECOND AND THIRD SURGICAL OPINIONS.

Subpart 1. **Second surgical opinion by medical review agent.** Except as provided in subpart 2, a second surgical opinion must be obtained from the medical review agent as specified in parts 9505.0520, subparts 6 and 8, and 9505.0540.

Subp. 2. **Second surgical opinion by a second physician.** If the department does not have a contract with the medical review agent to provide a second surgical opinion, a second surgical opinion must be obtained from a second physician.

Subp. 3. **Third surgical opinion.** If a second surgical opinion obtained under subpart 1 or 2 fails to substantiate the initial surgical opinion and the recipient still wants the surgery, a third surgical opinion shall be obtained from a third physician. 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 program.

Statutory Authority: *MS s 256.991; 256D.03 subd 7 para (b)*

History: *10 SR 842; 13 SR 1688*

9505.5055 SECOND OR THIRD OPINION BY A PHYSICIAN.

Subpart 1. **Duties of physician offering to provide the surgical service.** If the recipient requires the opinion of a second physician under part 9505.5050, subpart 2, or if the medical review agent or the second physician determines that the surgical procedure requiring a second surgical opinion is medically inappropriate and the recipient needs a third opinion under part 9505.5050, subpart 3, the physician offering to provide the surgical service shall provide to the recipient in need of the second or third surgical opinion the names of at least two other physicians who are qualified to render the surgical 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 or third opinion is 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 and must meet the criteria on experience in treating and diagnosing the condition that requires a second or third surgical opinion as published in the State Register under part 9505.5035.

Statutory Authority: *MS s 256.991; 256D.03 subd 7 para (b)*

History: *10 SR 842; 10 SR 1688*

9505.5060 PENALTIES.

The penalties for failure to comply with parts 9505.5000 to 9505.5100 shall be imposed in accordance with parts 9505.2160 to 9505.2245 in addition to parts 9505.0145, 9505.0465, and 9505.0475.

Statutory Authority: *MS s 256.991; 256D.03 subd 7 para (b)*

History: *10 SR 842; 13 SR 1688*

9505.5065 REIMBURSEMENT OF COST OF SECOND AND THIRD SURGICAL OPINIONS.

Reimbursement of the cost of a second or third surgical opinion 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; 256D.03 subd 7 para (b)*

History: *10 SR 842; 13 SR 1688*

9505.5070 TIME LIMITS; SECOND AND THIRD OPINIONS; SURGERY.

The second surgical opinion from the medical review agent or a second physician shall be obtained within 90 days of the date of the initial opinion. The surgical opinion from a third physician, if required, shall be obtained within 45 days of the date of the opinion of the medical review agent or the second physician. 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; 256D.03 subd 7 para (b)*

History: *10 SR 842; 13 SR 1688*

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, and shall be attached to a completed and signed prior authorization form. The completed form must be returned to the physician offering to provide the surgical service and must be retained and made available, for at least five years, by the physician to the department as provided in part 9505.5080, or, on request, to a medical review agent under contract to the department.

Statutory Authority: *MS s 256.991; 256D.03 subd 7 para (b)*

History: *10 SR 842; 13 SR 1688*

9505.5080 FAILURE TO OBTAIN REQUIRED OPINIONS.

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

Subp. 2. **Opinion of second or third physician.** Failure of a physician who offers to provide a surgical procedure requiring a second opinion to obtain the required surgical opinion from a second or third physician 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 the providers who rendered the second or third surgical opinion.

Subp. 3. **Submission of completed form to department.** If the second or third opinion by a physician does not substantiate the need for the surgical procedure and if the department does not have a contract with a medical review agent, then the physician offering to provide the surgical procedure shall submit the completed form 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; 256D.03 subd 7 para (b)*

History: *10 SR 842; 13 SR 1688*

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 MEDICAL REVIEW AGENT AND DEPARTMENT RESPONSIBILITY.

Subpart 1. **Medical review agent responsibility.** Except as provided in subpart 2, if the medical review agent agrees that the requested surgical procedure is medically appropriate, the medical review agent shall certify that the requirements of this part are met, shall assign an authorization number within one working day of the medical review agent's receipt of the information, and shall issue a hospital admission certification number if the procedure requires inpatient hospital admission.

If the third physician, consulted according to part 9505.5050, subpart 3, agrees with the physician offering to provide the surgical service that the requested surgical procedure is medically appropriate, the medical review agent shall certify that the requirements of this part are met, shall assign an authorization number within one working day of the medical review agent's receipt of the necessary information and forms, and shall issue a hospital certification number.

If the third physician agrees with the second opinion provided by the medical review agent that the requested surgical procedure is not medically appropriate, then the medical review agent shall deny an authorization number and a certification number and the department shall deny authorization of reimbursement for the requested surgical procedure. The medical review agent 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.

Subp. 2. **If no medical review agent.** The department shall assign or deny an authorization number when the department does not have a contract with a medical review agent to determine the medical appropriateness of procedures requiring second surgical opinions.

If two of the three physicians agree that the requested surgical procedure is medically 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 agree 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; 256D.03 subd 7 para (b)*

History: *10 SR 842; 13 SR 1688*

9505.5095 [Repealed, 13 SR 1688]

9505.5096 REQUEST FOR EXEMPTION FROM SECOND SURGICAL OPINION.

Subpart 1. **Request for exemption; general.** A provider who believes a surgical procedure is exempt under part 9505.5040 from the second or third opinion requirement shall request approval of the exemption from the medical review agent or the department before carrying out the surgical procedure, except for exemptions under part 9505.5040, items B, C, and F, which may be requested after performing the surgical procedure.

Subp. 2. **Request for exemption before carrying out surgical procedure.** A provider shall request approval of the exemption either under item A or B.

A. If the department has a contract with a medical review agent, the provider shall call the medical review agent and provide the information required in parts 9505.5000 to 9505.5030.

B. If the department does not have a contract with a medical review agent, the provider shall submit the request to the department according to the prior authorization procedures in part 9505.5010.

Subp. 3. **Request for exemption after performing the surgical procedure.** If a provider chooses to carry out the surgical procedure before requesting approval of the exemption, the provider shall request approval of the exemption under item A or B.

A. If the department has a contract with a medical review agent, the provider shall submit to the medical review agent the medical records related to the recipient's medical condition, diagnosis, and treatment.

B. If the department does not have a contract with a medical review agent, the provider shall submit the request to the department according to the procedures in part 9505.5015.

Subp. 4. **Retroactive eligibility.** A hospital may seek an authorization number 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 physician offering to provide the surgical service of the authorization number of a retroactively eligible recipient. The physician offering to provide the surgical service and the hospital shall not seek an authorization number 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 appropriateness of the surgical procedure. Failure to submit a requested record within 30 days of the request shall result in denial of the authorization number.

Subp. 5. **Documentation required.** A provider who believes a surgical procedure is exempt from the second and third opinion requirement under part 9505.5040 must submit supporting documentation with the request for exemption. If the provider requests approval of the exemption before performing the procedure, the department or medical review agent, as appropriate, may withhold approval of the exemption until the provider has submitted the documentation.

Statutory Authority: *MS s 256.991; 256D.03 subd 7 para (b)*

History: *13 SR 1688*

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 9505.2160 to 9505.2245, that the requested surgical procedure is not medically appropriate. 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 used. If the selected physician determines the procedure is not medically appropriate, the commissioner shall deny authorization.

Statutory Authority: *MS s 256.991; 256D.03 subd 7 para (b)*

History: *10 SR 842; 13 SR 1688*

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, sections 256B.02, subdivision 8 and 256B.0625.

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 or the medical review agent. The commissioner's ruling shall be binding upon the department and the recipient unless a request for judicial review is filed pursuant to Minnesota Statutes, section 256.045, subdivision 7.

Statutory Authority: *MS s 256.991; 256D.03 subd 7 para (b)*

History: *10 SR 842; L 1988 c 689 art 2 s 268; 13 SR 1688*