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 All persons should be aware that parts 9505.0010 to 9505.0150 of the medical assistance program may be superseded by a change in state or federal law or by a court order prior to the agency having an opportunity to amend these rules.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

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

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

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

History: *11 SR 1069; 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 calendar months before the month of application may be used to satisfy the spend-down. The person has the right to choose the beginning month of the six-month eligibility period. The choice is limited to the

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

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

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

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

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

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

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

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

Statutory Authority: *MS s 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 a parent must be determined under subpart 6 if the responsible spouse or parent provides the information needed to make the determination. The responsible spouse or parent who refuses to provide information needed to determine the financial obligation under subparts 3 and 6 is obligated to reimburse the local agency for the full amount of medical assistance paid for health services provided to the recipient. The local agency may reduce the amount to be paid on the financial obligation determined under subpart 3 or 6 if payment of the financial obligation will cause the responsible relative undue hardship. In no case shall the financial obligation determined under subpart 3 or 6 for the responsible spouse or parent exceed the amount of medical assistance ultimately provided the recipient.

Subp. 2. **Consideration of spouses' assets and income.** The assets and income

of spouses living together must be considered available to each spouse in determining medical assistance eligibility for either or both spouses. When spouses do not live together, the presumption of availability of spousal assets and income ends on the first day of the month following the month in which the spouses cease living together.

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

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

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

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

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

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

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

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

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

960 -	1,124	$116 plus 50 percent of the amount over $960
1,125 -	and over	$198 plus 100 percent of the amount over $1,125

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

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

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

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

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

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

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

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

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

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

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

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

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

G. If a child is under 18 and living together with the parents and the child's eligibility for medical assistance was determined without consideration of the parent's income and assets as part of a home and community based waiver

under Minnesota Statutes, sections 256B.49 and 256B.491, the parent's income must be considered in regard to an obligation under subpart 6, item D.

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

A. A parent has no obligation to contribute assets.

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

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

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

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

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

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

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

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

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

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

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

History: *11 SR 1069; L 1987 c 258 s 12*

9505.0080 COOPERATION WITH QUALITY CONTROL REVIEW.

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

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

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

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

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

History: *11 SR 1069*

9505.0085 RIGHT TO APPLY; MAKING APPLICATION.

Subpart 1. **Applying for medical assistance.** Any person or the person's authorized representative may apply for medical assistance at the local agency in the county of the person's residence, or in the county of the authorized representative's residence, or in the county of financial responsibility. The local agency that receives a request for medical assistance from an individual either by telephone or in person shall inform the individual of the eligibility factors and requirements and the procedure for making a written application. The local agency shall inform the individual that he or she has a right to apply for medical assistance, regardless of the agency's informal assessment as to the likely eligibility of the individual. The application must be completed by the applicant or the applicant's authorized representative, on the application form prescribed by the department. A local agency shall not require an individual to appear at the local agency for an interview or to submit verification of eligibility factors before the date when the individual submits the completed application form. The local agency shall accept the application and provide the applicant with information about the eligibility factors. The date of the application shall be as defined in part 9505.0015, subpart 5. An applicant may apply for eligibility consideration of up to three calendar months prior to the month of application.

Subp. 2. **Application by authorized representative.** A person who is incapable of completing the application or providing the information and verifications

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

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

History: *11 SR 1069*

9505.0090 LOCAL AGENCY ACTION ON APPLICATION.

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

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

Subp. 3. **Required notice in case of delay.** If the information and documentation required by parts 9505.0010 to 9505.0150 are not obtained within the time limit, the local agency shall notify the applicant, in writing, about the deficiencies of the application, the reason for the delay in determining the applicant's eligibility, and the applicant's right to appeal the agency's delay of a decision under part 9505.0130.

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

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

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

Subp. 4. **Withdrawal of application.** An applicant may withdraw his or her application at any time by giving written or oral notice to the local agency. The local agency shall issue a written notice confirming the withdrawal. The notice must inform the applicant of the local agency's understanding that the applicant has withdrawn the application and no longer wants to pursue it. When, within ten days of the date of the agency's notice, an applicant informs a local agency in writing that he or she does not want to withdraw the application, the local agency shall reinstate, and finish processing the application.

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

History: *11 SR 1069*

9505.0095 VERIFICATION OF ELIGIBILITY INFORMATION.

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

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

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

History: *11 SR 1069*

9505.0100 NOTICE OF AGENCY DECISION ON ELIGIBILITY.

The local agency must notify a person, in writing, in the format determined by the department, of the agency's decision on the person's medical assistance eligibility. The notice must be sent within the time limits set in part 9505.0090 and comply with the requirements of part 9505.0150. If the determination is to deny eligibility, the local agency shall give the person the reasons for the denial and state the person's right to appeal the denial as provided in part 9505.0130.

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

History: *11 SR 1069*

9505.0105 APPLICATION FOR STATE HOSPITAL RESIDENTS.

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

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

History: *11 SR 1069*

9505.0110 PERIODS OF ELIGIBILITY.

Subpart 1. **Retroactive eligibility.** Retroactive eligibility is available for the three calendar months before the month of application. Retroactive eligibility must be determined as if the applicant had applied in the retroactive month except for the reduction of excess assets as in part 9505.0063, subpart 1. Retroactive eligibility is available on the date after the day on which excess assets are reduced under part 9505.0063, subpart 1. Retroactive eligibility does not depend on a finding of eligibility for the month of application or for all of the months in the retroactive period and is not limited to consecutive months in the retroactive period.

Subp. 2. **Other periods of eligibility.** Other periods of eligibility shall be as in items A to D:

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

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

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

D. A person retaining medical assistance eligibility after termination of

aid to families with dependent children under part 9505.0055, subpart 3, is eligible for medical assistance for the period specified in that subpart.

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

A. eligibility ends because the person dies; or

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

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

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

History: *11 SR 1069*

9505.0115 REDETERMINATION OF ELIGIBILITY.

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

Subp. 2. **Redetermination after change in eligibility factor.** The local agency shall redetermine eligibility if a change in an eligibility factor is reported. The redetermination must be completed so that the change can go into effect by the second month following the month of the change.

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

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

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

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

History: *11 SR 1069*

9505.0120 REAPPLICATION.

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

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

History: *11 SR 1069*

9505.0125 NOTICE OF DENIAL OR TERMINATION.

Subpart 1. **Notice to applicant or recipient.** The local agency or department shall send the person a written notice, in the format prescribed by the 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 9505.1750 to 9505.2150.

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

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

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

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

History: *11 SR 1069*

9505.0140 PAYMENT FOR ACCESS TO MEDICALLY NECESSARY SERVICES.

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

A. Sign language interpreter, if a hearing-impaired person must have an interpreter in order to receive health services from a provider with fewer than 15 employees.

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

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

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

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

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

Statutory Authority: *MS s 256B.04 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 9505.0491 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 staff person qualified under part 9520.0760, subpart 17 to provide clinical services in the treatment of mental illness.

Subp. 28. **Mental health professional.** "Mental health professional" has the meaning given it in part 9505.0477, subpart 17.

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. Examples of a performance agreement are 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, and a hearing aid performance agreement between the department and a hearing aid dispenser as specified in part 9505.0365, subpart 1, item D.

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 subds 4,12; 256B.0625 subd 20*

History: *12 SR 624; L 1988 c 689 art 2 s 268; 13 SR 1439*

9505.0180 SURVEILLANCE AND UTILIZATION CONTROL PROGRAM.

Subpart 1. **Purpose.** For purposes of this part, "surveillance and utilization review" has the meaning given in part 9505.1750, subpart 15 and "utilization control" has the meaning given in part 9505.1750, subpart 19.

Subp. 2. **Duty to implement.** The department shall carry out a program of a surveillance and utilization review under parts 9505.1750 to 9505.2150 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 9505.1750 to 9505.2150.

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 subds 4,12*

History: *12 SR 624*

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 9505.1750 to 9505.2150.

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 9505.1750 to 9505.2150, 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 9505.1750 to 9505.2150 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 9505.1750 to 9505.2150 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 9505.1750 to 9505.2150.

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 9505.1750 to 9505.2150.

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 he or she 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*

9505.0215 COVERED SERVICES; OUT-OF-STATE PROVIDERS.

A health service provided to a Minnesota recipient by a provider located outside of Minnesota is eligible for medical assistance payment if the service meets one of the following requirements.

A. The health service is within the limitations of parts 9505.0170 to 9505.0475.

B. The service is medically necessary and is not available in Minnesota or the recipient's local trade area. Provision of the service, other than an emergency service, outside of Minnesota or the recipient's local trade area requires prior authorization.

C. The service is provided to a person who is considered a Minnesota medical assistance recipient while residing out-of-state as specified in part 9505.0055, subparts 4 and 5.

D. The service is in response to an emergency.

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

History: *12 SR 624*

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.

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 subds 4,12*

History: *12 SR 624*

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, rhoGAM(TM), pap smear, and laboratory examinations for the purpose of detecting fetal abnormalities.

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

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

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

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

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

Statutory Authority: *MS s 256B.04 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 317; and

B. has tax exempt status as provided in Internal Revenue Code, section 501(c)(3) as amended through October 4, 1976; 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 subds 4,12*

History: *12 SR 624*

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 authorization. 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*

9505.0290 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 9500.1070, subparts 12 and 13, 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 subds 4,12*

History: *12 SR 624*

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 9500.1070, subparts 12 and 13;

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 depen-

dent 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 subds 4,12*

History: *12 SR 624; 13 SR 1448*

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 acknowledgement 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 acknowledgement 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*

9505.0325 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 Vocational Technical Education;

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 9505.1750 to 9505.1880;

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 9505.1750 to 9505.2150. 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*

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 following 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. "Audiologist" means a person who has a current certificate of clinical competence from the American Speech, Language, and Hearing Association.

C. "Hearing aid" means a prosthetic or orthotic device that aids or improves a person's auditory function.

D. "Hearing aid dispenser" means a person or entity who specializes in the sale and repair of hearing aids and has signed a performance agreement with the department.

E. "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.

F. "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. **Payment limitation; hearing aid.** To be eligible for medical assistance payment, a hearing aid must be ordered by a physician in consultation with an audiologist. Payment for hearing aids and their maintenance and repair is limited as in items A to E. A request for prior authorization as required in items A and B must be approved or denied no later than one month after the department has received information necessary to determine whether the service is medically necessary.

A. One monaural aid or one set of binaural aids in a five year period unless prior authorization is obtained.

B. One repair per calendar year unless prior authorization is obtained. The vendor of the repair must itemize the charges.

C. One visit per calendar year to the recipient's residence by a hearing aid dispenser unless prior authorization is obtained. The visit to the residence must be medically necessary.

D. Replacement batteries as necessary to maintain the hearing aid's effectiveness.

E. Service to test, prescribe, or fit a hearing aid for a resident of a long-term care facility when need for the hearing aid is established in the resident's plan of care.

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 K 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 or 4;

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 or 4. 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; and

K. replacement batteries provided on a schedule under contract.

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

History: *12 SR 624*

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*

9505.0395 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*

9505.0415 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. Examples of over the counter drugs or supplies are aspirin, aspirin compounds, acetaminophen, antacids, antidiarrheals, cough syrups, rubbing alcohol, talcum powder, body lotion, petrolatum jelly, lubricating jelly, and mild antiseptic solutions.

Statutory Authority: *MS s 256B.04 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 N.

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 provided in a physician supervised clinic, the rate shall be the lower of the provider's submitted charge or the 75th percentile of all screening charges submitted by physician supervised clinics during the previous six month period of November to April. For EPSDT services provided in a nurse supervised clinic, the rate shall be the lower of the provider's submitted charge or the 75th percentile of all screening charges submitted by nurse supervised clinics during the previous six month period of November to April. The adjustment necessary to reflect the 75th percentile shall be effective annually on August 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 subds 4,12*

History: *12 SR 624; L 1987 c 209 s 39*

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 9505.1750 to 9505.2150.

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 9505.1750 to 9505.2150.

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*

CASE MANAGEMENT SERVICES FOR PERSONS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS

9505.0476 SCOPE AND AVAILABILITY.

Subpart 1. **Scope.** Parts 9505.0476 to 9505.0491 establish standards and procedures for providing case management services to persons with serious and persistent mental illness, as authorized by Minnesota Statutes, sections 245.461 to 245.486 and 256B.02, subdivision 8t. Parts 9505.0476 to 9505.0491 are intended to be in compliance with and, therefore, must be read in conjunction with title XIX of the Social Security Act; Code of Federal Regulations, title 42, sections 430 to 456 as amended through October 1, 1987; Minnesota Statutes, sections 245.461 to 245.486, 245.64, 256E.09, and Minnesota Statutes, chapters 256B and 256G; and parts 9505.1750 to 9505.2150.

Subp. 2. **Availability.** Case management services are available to all medical assistance recipients with serious and persistent mental illness and to other persons with serious and persistent mental illness within the limits of appropriations as specified in Minnesota Statutes, section 245.486, except as provided under part 9505.0479. Additionally, case management services to recipients who have serious and persistent mental illness are to be provided according to Minnesota Statutes, section 245.464. In making case management services available to persons with serious and persistent mental illness who are not recipients of medical assistance, a local agency shall use all possible available funding sources. Examples of possible funding sources are grants to counties for services to persons with serious and persistent mental illness under Minnesota Statutes, section 256E.12, funds made available to counties for community social services under Minnesota Statutes, sections 256E.06 and 256E.07, money distributed to counties for permanency planning for children under Minnesota Statutes, sections 256F.01 to 256F.07, and title XX allocations under Minnesota Statutes, section 256E.07.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

9505.0477 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9505.0476 to 9505.0491 have the meanings given them in this part and in part 9505.0175.

Subp. 2. **Case manager.** "Case manager" means an individual who meets the qualifications specified in Minnesota Statutes, section 245.462, subdivision 4, and part 9505.0484, subpart 1, and who is employed by or under contract to a case management provider authorized to provide case management services under parts 9505.0476 to 9505.0491.

Subp. 3. **Case management provider.** "Case management provider" means a local agency that directly provides case management services or an entity that is

under contract with the local agency to provide case management services and meets the requirements of a medical assistance provider under part 9505.0195.

Subp. 4. **Case management services.** "Case management services" means services specified in Minnesota Statutes, section 245.462, subdivision 3, and part 9505.0485 that help persons with serious and persistent mental illness gain access to needed medical, social, educational, financial, and other services necessary to meet their mental health needs and that coordinate and monitor the delivery of these services.

Subp. 5. **Child or minor.** "Child" or "minor" means a person under 18 years old.

Subp. 6. **Client.** "Client" means a person with serious and persistent mental illness who is receiving case management services under parts 9505.0476 to 9505.0491.

Subp. 7. **Clinical supervision.** "Clinical supervision" means the responsibility of a mental health professional employed by or under contract with the case management provider to oversee the client-related activities of a case manager as specified in Minnesota Statutes, section 245.462, subdivision 25, and part 9505.0484, subpart 2.

Subp. 8. **Community support services program.** "Community support services program" means the services specified in Minnesota Statutes, section 245.462, subdivision 6.

Subp. 9. **County of financial responsibility.** "County of financial responsibility" has the meaning given in Minnesota Statutes, section 256G.02, subdivision 4.

Subp. 10. **Diagnostic assessment.** "Diagnostic assessment" means a written evaluation by a mental health professional of a person's:

A. current life situation and sources of stress, including reasons for referral;

B. history of the person's current mental health problem, including important developmental incidents, strengths, and vulnerabilities;

C. current functioning and symptoms;

D. diagnosis including whether or not a person is seriously and persistently mentally ill; and

E. needed mental health services.

Subp. 11. **Emergency services.** "Emergency services" means an immediate response service available on a 24-hour, seven-day-a-week basis as required under Minnesota Statutes, section 245.469, for persons having a psychiatric crisis or emergency.

Subp. 12. **Functional assessment.** "Functional assessment" means an evaluation by the case manager of the client's:

A. mental health symptoms as presented in the client's diagnostic assessment;

B. mental health needs as presented in the client's diagnostic assessment;

C. use of drugs and alcohol;

D. vocational and educational functioning;

E. social functioning, including the use of leisure time;

F. self care and independent living capacity;

G. interpersonal functioning, including relationships with his or her family;

H. medical and dental health;

I. financial assistance needs;

J. current living conditions and housing needs; and

K. other needs and problems.

Subp. 13. **Individual community support plan.** "Individual community support plan" means a written plan developed by a case manager together with the client that is based on a diagnostic assessment and the client's needs and that is coordinated with the client's individual treatment plan or plans as defined in subpart 14. The plan identifies the specific services to be provided that are appropriate to the age of the person with serious and persistent mental illness and that the person needs to develop independence or improved functioning in daily living, health and medication management, social functioning, interpersonal relationships including family relationships, financial management, housing, transportation, employment, and education. A child's individual community support plan also identifies activities related to involving the child's family or primary caregiver in the specific services to be provided including, as appropriate, services specified in Minnesota Statutes, sections 256F.07, subdivision 3, and 257.071, subdivision 1.

Subp. 14. **Individual treatment plan.** "Individual treatment plan" means a written plan of intervention, treatment, and services for a person with mental illness that is developed by the client and a mental health professional which is based on a diagnostic assessment and the client's needs. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individual or individuals responsible for providing treatment to the person with serious and persistent mental illness. A child's individual treatment plan also identifies activities related to involving the child's family or primary caregiver in the treatment of the child and, if the child is placed or being considered for placement outside the home, includes the individual placement plan as required under Minnesota Statutes, section 257.071, subdivision 1.

Subp. 15. **Inpatient hospital.** Notwithstanding the definition in part 9505.0175, subpart 16, "inpatient hospital" means an acute care institution defined in Minnesota Statutes, section 144.696, subdivision 3, and licensed under Minnesota Statutes, sections 144.50 to 144.58.

Subp. 16. **Legal representative.** "Legal representative" means a court-authorized guardian of a child with serious and persistent mental illness, or a guardian or conservator authorized by the court to make decisions about services for a person with serious and persistent mental illness.

Subp. 17. **Mental health professional.** "Mental health professional" means a person who provides clinical services in the treatment of mental illness and who, at a minimum, is qualified in at least one of the ways specified in Minnesota Statutes, section 245.462, subdivision 18, clauses (1) to (5).

After August 1, 1989, persons in allied fields as specified in Minnesota Statutes, section 245.462, subdivision 18, clause (5), shall be required to file their credentials as required by Minnesota Statutes, section 148B.42, subdivision 1.

Subp. 18. **Mental health provider.** "Mental health provider" means an individual, agency, or facility that provides mental health services, other than case management services, to a client.

Subp. 19. **Mental health services.** "Mental health services" means the services provided to persons with mental illness that are described in Minnesota Statutes, section 245.466, subdivision 2.

Subp. 20. **Mental illness.** "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IIIR), current edition, Axes I, II, or III, and that seriously limits a person's

capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation. The ICD-9-CM and DSM-IIIR are incorporated by reference. The International Classification of Diseases — Clinical Modification is published by the Commission of Professional and Hospital Activities, Green Road, Ann Arbor, Michigan 48105. The Diagnostic and Statistical Manual of Mental Disorders is published by The American Psychiatric Association, 1700 18th Street N.W., Washington, D.C. 20009. The ICD-9-CM and the DSM-IIIR are available through the Minitex Interlibrary loan system and are subject to frequent change.

Subp. 21. **Outpatient services.** "Outpatient services" means the services specified in Minnesota Statutes, section 245.462, subdivision 21.

Subp. 22. **Parent.** "Parent" means the birth or adoptive mother or father of a child. This definition does not apply to a person whose parental rights have been terminated in relation to the child.

Subp. 23. **Primary caregiver.** "Primary caregiver" means a foster parent, a relative who is not the child's parent, or other person who has primary responsibility for providing the child food, clothing, shelter, supervision, and nurture and with whom the child resides.

Subp. 24. **Regional treatment center.** "Regional treatment center" means a regional center as defined in Minnesota Statutes, sections 253B.02, subdivision 18, and 254.05.

Subp. 25. **Residential treatment.** "Residential treatment" refers to a treatment program and 24-hour-a-day supervision of a person in a community residential setting other than an inpatient hospital or regional treatment center. Both the treatment program and the person are clinically supervised by a mental health professional.

Subp. 26. **Residential treatment facility.** "Residential treatment facility" means a facility in the community that provides residential treatment and is licensed as a residential treatment facility under parts 9520.0500 to 9520.0690 for adults with mental illness, or parts 9545.0900 to 9545.1090 for children who are emotionally disturbed.

Subp. 27. **Serious and persistent mental illness.** "Serious and persistent mental illness" means the condition of an adult or child who has a mental illness and meets at least one of the following criteria:

A. the person has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;

B. the person has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

C. the person has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder, indicates a significant impairment in functioning, and has a written opinion from a mental health professional stating that the person is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in item A or B, unless an ongoing community support services program is provided; or

D. the person is currently under commitment by a court as a mentally ill person under Minnesota Statutes, chapter 253B, or the person's commitment is under a stay or continuance for reasons related to the person's mental illness.

Subp. 28. **Service provider.** "Service provider" means an individual or agency that provides services to a client, other than mental health services or case management services.

Subp. 29. **Third party payer.** "Third party payer" means a person, entity, agency, or government program, other than Medicare or medical assistance, that has a probable obligation to pay all or part of the costs of a person's health services.

Subp. 30. **Waiver.** "Waiver" means an approval given by the United States Department of Health and Human Services that allows the state to pay for home and community-based services authorized under Code of Federal Regulations, title 42, section 441, subpart G, for a particular group of recipients. The term applies to all amendments to the waiver including any amendments made after the effective date of parts 9505.2390 to 9505.2500 (August 8, 1988), as approved by the United States Department of Health and Human Services.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

9505.0478 REFERRAL FOR CASE MANAGEMENT SERVICES.

Consistent with the Minnesota Governmental Data Practices Act, and Minnesota Statutes, section 245.467, subdivisions 4 and 6, a physician, a mental health provider, a family member, a social worker, a legal representative, or other interested person may give the name and address of a person believed to have serious and persistent mental illness to the local agency and request case management services for the person. A person who may have serious and persistent mental illness may directly request case management services from the local agency.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

9505.0479 COORDINATION OF CASE MANAGEMENT SERVICES WITH OTHER PROGRAMS.

Subpart 1. **Persons receiving services through the Veterans Administration.** Persons with serious and persistent mental illness who are receiving case management services through the Veterans Administration are not eligible for case management services while they are receiving case management through the Veterans Administration.

Subp. 2. **Persons receiving home and community based services.** Persons receiving home and community based services authorized under a waiver are not eligible for case management services under parts 9505.0476 to 9505.0491 while they are receiving the waivered services. For purposes of this subpart, "home and community based services authorized 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.

Subp. 3. **Persons with dual diagnoses.** Except as provided in subpart 2, if a person has the diagnosis of mental retardation or a related condition and the diagnosis of serious and persistent mental illness, the county shall assign the person a case manager for services to persons with mental retardation according to parts 9525.0015 to 9525.0165 and shall notify the person of the right to receive case management services for persons with serious and persistent mental illness according to parts 9505.0476 to 9505.0491. If the person or the person's representative chooses case management services for persons with serious and persistent mental illness, the case manager assigned under parts 9525.0015 to 9525.0165 and the case manager chosen under parts 9505.0476 to 9505.0491 shall work together as a team to ensure that the person receives the services required under parts 9525.0015 to 9525.0165 and 9505.0476 to 9505.0491. The case manager responsible for the person's individual community support plan under parts 9505.0476 to 9505.0491 shall:

A. coordinate the team's work;

B. be responsible for developing one service plan that satisfies the requirements of parts 9505.0476 to 9505.0491 and 9525.0015 to 9525.0165;

C. arrange with the case manager assigned under parts 9525.0015 to

9525.0165 the consultations necessary for a determination of the person's needs and a review of the person's case records, diagnoses, and service needs;

D. coordinate meetings required under parts 9505.0476 to 9505.0491 and 9525.0015 to 9525.0165 to encourage the participation of the person, the person's family, the person's legal representative or advocate as defined in part 9525.0015, subpart 3, if any, and other affected individuals; and

E. assure that the required meetings and actions take place according to the time interval specified for the meeting or action under parts 9505.0476 to 9505.0491 or 9525.0015 to 9525.0165, whichever is shorter.

Subp. 4. **Person enrolled in medical assistance demonstration project.** For purposes of parts 9505.0476 to 9505.0491, a person with serious and persistent mental illness who is enrolled by a demonstration provider under the medical assistance demonstration project established under Minnesota Statutes, section 256B.69, is eligible for case management services as specified in parts 9505.0476 to 9505.0491 on a fee-for-service basis from a provider other than the demonstration provider.

Subp. 5. **Person assessed as chemically dependent under part 9530.6620.** A person who has been assessed as chemically dependent under part 9530.6620 and who is also determined to have serious and persistent mental illness is eligible to receive case management services under parts 9505.0476 to 9505.0491.

The case manager assigned under parts 9505.0476 to 9505.0491 must coordinate the person's case management services with any similar services the person is receiving from other sources.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

9505.0480 LOCAL AGENCY RESPONSIBILITIES.

Subpart 1. **Local agency responsibility; general requirement.** The local agency must make case management services available under parts 9505.0476 to 9505.0491 either directly or under a contract with a case management provider. The services must be provided to recipients who request them and, within the limitations of Minnesota Statutes, section 245.486, to persons other than recipients. The recipients and persons other than recipients must have been determined by a mental health professional to have serious and persistent mental illness or must have been determined by the local agency to meet the requirements in part 9505.0477, subpart 27, item A, B, or D. As required by Minnesota Statutes, section 245.464, subdivision 2, the local agency must develop mental health services for all persons with serious and persistent mental illness to the extent of the county's available resources. The first source of payment for case management services to a person with serious and persistent mental illness shall be Medicare or a third party payer wherever possible.

Subp. 2. **Notice of availability.** Within five working days after receiving a request or referral for case management services, the local agency must mail a written notice of the availability of case management services to the last known address of the person for whom case management services were requested and to the person who made the request or referral. If the person for whom case management services have been requested is a child, notice must be mailed to the child and, except as provided in subpart 5, to the child's parents, legal representative, or primary caregiver or, in the case of divorced parents having joint custody, the notice must be sent to the parent with whom the child resides. The local agency must document in a child's case record why a notice is not sent to a child's parents, legal representative, or primary caregiver. The notice must be on a form supplied by the commissioner, explain that the person may be eligible for case management services, and list the names and telephone numbers of the case management providers in the county. The notice also must state that

the person has the right to a diagnostic assessment to determine eligibility for case management services and may contact the local agency during business hours for assistance in arranging for a diagnostic assessment by a mental health professional.

Subp. 3. **Notice when there is no known address.** If the local agency does not receive the person's address from the individual making the referral under subpart 1, the local agency must make a reasonable attempt to locate the person for whom case management services have been requested and give the person notice of the availability of case management services as described in subpart 2. If the person referred is a child, the local agency must attempt to locate the child and child's parents or legal representative. The local agency must document the completed contacts and the contacts attempted.

Subp. 4. **Follow-up notice of availability of case management services.** If the person notified under subparts 2 and 3 does not respond within ten working days after the local agency gives the required notice, the local agency must make a reasonable attempt to contact the person, or if the person is a child, the child's parents, primary caregiver, or legal representative. Contact must be either face-to-face or by telephone. If the local agency is able to contact the person, the local agency must ask whether the person who may have serious and persistent mental illness wants to be assessed for eligibility for case management services. The local agency must document the attempted and completed contacts, describing the type and content of contact made, and the result of the contact.

Subp. 5. **Notice to child's parent, legal representative, or primary caregiver.** When notice to a parent, legal representative, or primary caregiver with whom the child is living is required under parts 9505.0476 to 9505.0491, the local agency or case manager responsible for giving notice shall notify that person unless item A or B applies.

A. The parent, legal representative, or primary caregiver with whom the child is living is hindering or impeding the child's access to mental health services or 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 his or her parents or legal guardian and is managing his or her 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).

B. 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 applies, the local agency or case manager, as appropriate, shall provide notice to the child.

If item B applies, the local agency or case manager, as appropriate, shall provide notice to the guardian ad litem.

Subp. 6. **Refusal.** A person may refuse case management services. A person's refusal of case management services does not affect the person's eligibility to receive case management services as long as the person is seriously and persistently mentally ill.

Subp. 7. **Determination of eligibility for case management services.** When a person requests or is referred for case management services, consents to be assessed for eligibility for the services, and authorizes a release of information, the local agency must determine whether the person meets a requirement of part

9505.0477, subpart 27, item A, B, or D, or must offer to help the person arrange a diagnostic assessment by a mental health professional, unless one has already been completed within 90 days before the request or referral.

Subp. 8. **Arranging for diagnostic assessment.** If a person accepts the local agency's offer to help arrange a diagnostic assessment, the local agency must notify the mental health provider chosen by the person of the person's need for a diagnostic assessment and offer to help the person make an appointment with the mental health professional.

Subp. 9. **Access to case management services.** Within five days after a person who has been determined to have serious and persistent mental illness accepts case management services, the local agency must offer to help the person make an appointment with a case management provider. The appointment must be scheduled for no later than two weeks from the date it is made unless the person requests otherwise. The local agency must also inform the person of the availability of emergency services at the time the offer to schedule the appointment is made.

Subp. 10. **Local agency responsibility; continuity of care.** A local agency must ensure, either directly or in its contract with a case management provider, that the same case manager is continuously available to a client unless:

A. the case manager is no longer employed or contracted by the agency or the provider as a case manager;

B. the client requests a different case manager; or

C. the case manager is unable to provide effective case management services to the client and requests a change of assignment.

When there is a change of case manager, steps must be taken to ensure a smooth transition. The steps include a transfer of client records to the new case manager and a formal meeting of providers, the client, and in the case of a child the child's parent, legal representative, or primary caregiver, and both case managers, to discuss the client's case management services.

Subp. 11. **Local agency responsibility; referral to mental health and other service providers.** If a person with serious and persistent mental illness who is referred to a local agency for case management services refuses case management services or if a person referred to a local agency is determined to have a mental illness but not to have serious and persistent mental illness, the local agency shall offer to refer the person to a mental health provider or other service provider appropriate to the person's needs and, at the person's request, shall assist the person in making an appointment with the provider of the person's choice.

Subp. 12. **Local agency responsibility; retention of records.** A local agency shall develop and maintain an accurate, up-to-date list of the names and last known address of all persons who request, are referred for, or receive case management services. The records must be kept for five years after the date of the person's last request or referral for services or the case manager's termination of the person's services. The records shall be kept in accordance with the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13.

Subp. 13. **Local agency responsibility; child's preplacement screening.** In the case of a child with serious and persistent mental illness who receives case management services under parts 9505.0476 to 9505.0491, the local agency shall assure coordination of the child's case management services with the child's permanency planning, placement prevention, and family reunification services required under Minnesota Statutes, chapter 256F.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

9505.0481 OFFERING CASE MANAGEMENT SERVICES TO PERSONS ALREADY RECEIVING MENTAL HEALTH SERVICES.

If a person is in a regional treatment center, inpatient hospital, or residential treatment facility, or is receiving or requesting outpatient mental health services or other services through the community support service program and has been determined by a mental health professional to have serious and persistent mental illness, the mental health provider shall ensure that its representative informs the person of the availability of case management services under parts 9505.0476 to 9505.0491 and explains the purpose and potential benefit of case management services. The information must be given to a person within five days after admission to treatment in a regional treatment center, inpatient hospital, or residential treatment facility and within 15 days after admission to mental health services or treatment through the community support services program. If the person authorizes a release of information as specified in part 9505.0482, the representative of the mental health provider shall notify the local agency that the person wants case management services, and assure that the person has assistance in making an appointment with the case management provider of the person's choice. If the person is a child, the child and, except as provided in part 9505.0480, subpart 5, the child's parents, primary caregiver, or legal representative must be informed of the availability and purposes of case management services. The local agency must comply with the notice and follow-up requirements in part 9505.0480, subparts 2, 3, 4, and 5.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

9505.0482 AUTHORIZATION TO RELEASE INFORMATION AND CONTACT PERSON'S FAMILY.

Subpart 1. **Authorization to release information.** When a local agency, a case manager, or mental health professional asks a person requesting case management services to sign forms needed to gain access to information necessary to provide case management services or to share information with providers involved in providing services to the client, the information described in items A to H must be on the form above the person's signature. A separate form must be completed and signed for each authorization of access to a record related to the person's mental health status. The period of authorization must not exceed one year.

The form must contain:

A. the person's name;

B. the date;

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

D. the name of the person or persons authorized to give information;

E. the name of the person or persons to whom the information is to be given;

F. a description of the information's use during the case management services to determine eligibility for and provision of case management services;

G. the date the authorization expires; and

H. a statement that the person may revoke the consent at any time.

Subp. 2. **Authorization to contact person's family.** When parts 9505.0476 to 9505.0491 require a local agency, case manager, or mental health professional to contact the family of a person who has or may have a serious or persistent mental illness to obtain information related to the provision of the person's case management services, the local agency, case manager, or mental health professional shall ask the person to sign forms authorizing contact with the person's family. The information in items A to H must be on the form above the person's signature.

A separate form must be completed and signed for each family member to whom access is authorized. The period of authorization must not exceed one year for each family member. If the person does not sign the form authorizing contact with a family member, the local agency, case manager, or mental health professional may not contact the family member and shall note the person's refusal to sign in the person's case record.

The form must contain:

A. the person's name;

B. the date;

C. the specific nature of the information being sought in the contact;

D. the name of the family member with whom contact is being authorized;

E. the name of the person or persons who are authorized to contact the family member;

F. a description of the information's use during case management services to determine eligibility for and provision of case management services;

G. the date the authorization expires; and

H. a statement that the person may revoke the authorization at any time.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

9505.0483 DIAGNOSTIC ASSESSMENT.

Subpart 1. **Acceptance of diagnostic assessment.** A diagnostic assessment that can be used for determining a person's eligibility for case management services under parts 9505.0476 to 9505.0491 or in developing a client's individual community support plan must meet the requirements in items A to C and must contain the contents required in subpart 4.

A. A diagnostic assessment that was completed within 90 days before the person requested or was referred for case management services must be reviewed and brought up to date by a mental health professional if the person agrees to receive case management services.

B. If the person has not had a diagnostic assessment within 90 days before requesting or being referred for case management services, a new diagnostic assessment must be obtained.

C. The diagnostic assessment must result in a determination of whether the person has serious and persistent mental illness.

Subp. 2. **Assistance in obtaining a required diagnostic assessment.** If the person has not had a diagnostic assessment that meets the requirements of this part, a local agency or case manager, as appropriate, shall assist the person to obtain a diagnostic assessment required under subpart 1 by taking the following actions:

A. offer to assist the person to make an appointment for having the diagnostic assessment no later than ten days after receiving the request or referral for case management services;

B. request the mental health professional chosen by the person to complete the diagnostic assessment within ten days after the mental health professional has conducted the diagnostic assessment;

C. inform the mental health professional of the criteria that the diagnostic assessment must meet under parts 9505.0476 to 9505.0491;

D. request the mental health professional to provide a report of the findings when the mental health professional has completed the diagnostic assessment;

E. explain that the information can only be released with the client's consent;

F. inform the mental health professional that the client's authorization to release information must comply with the requirements of part 9505.0482, subpart 1; and

G. inform the mental health professional that the diagnostic assessment including identification of the client's needs must be completed no later than the second meeting between the person and the mental health professional conducting the diagnostic assessment.

Subp. 3. **Eligibility to provide a diagnostic assessment.** A diagnostic assessment required for parts 9505.0476 to 9505.0491 shall be conducted by the providers in items A and B.

A. In the case of a recipient, a recipient's diagnostic assessment completed before September 1, 1990, must be conducted by a mental health professional who is a provider and who is a psychiatrist, licensed consulting psychologist, or licensed psychologist, or conducted by a mental health professional who is under the clinical supervision of a provider who is a psychiatrist, a physician who is not a psychiatrist, or a licensed consulting psychologist. Beginning September 1, 1990, a person's diagnostic assessment must be conducted by a mental health professional who is a provider.

B. In the case of a person who is not a recipient, the person's diagnostic assessment must be conducted by a mental health professional as defined in Minnesota Statutes, section 245.462, subdivision 18.

Subp. 4. **Required contents of diagnostic assessments.** For purposes of parts 9505.0476 to 9505.0491, a diagnostic assessment must meet the criteria in items A to D. Additionally, the diagnostic assessment must show that the mental health professional conducting the diagnostic assessment considered the person's need for referral for psychological testing, a neurological examination, a physical examination, and a chemical dependency assessment as specified in part 9530.6615. A neurological examination, psychological testing, physical examination, and diagnostic assessment of a recipient are eligible for medical assistance payment billed as separate procedures.

A. The diagnostic assessment must address the components in part 9505.0477, subpart 10.

B. The diagnostic assessment must include a face-to-face interview, a mental status examination, and a review of pertinent records. For purposes of this item, "mental status examination" means the description of the client's appearance, general behavior, motor activity, speech, alertness, mood, cognitive functioning, and attitude toward his or her symptoms.

C. The diagnostic assessment must include contact with the child's parent, legal representative, or primary caregiver if appropriate under part 9505.0480, subpart 5, and to the extent necessary and reasonable to complete the diagnostic assessment; or contact with the client's family, if clinically appropriate and to the extent authorized by the client under part 9505.0482, subpart 2. The report of the diagnostic assessment must document the inclusion of the child's parent, legal representative, or primary caregiver, or the client's family or, if applicable, the reason why they were not included.

D. The diagnostic assessment must identify the needs that must be addressed in the individual treatment plan if the client is determined to be mentally ill.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

9505.0484 CASE MANAGER QUALIFICATIONS AND TRAINING.

Subpart 1. **Qualifications of case manager.** Except as provided in subpart 2, a case manager must have a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and have at least 2,000

hours of supervised experience in the delivery of services to persons with mental illness, be skilled in the process of identifying and appraising a wide range of client needs, and be knowledgeable about local community resources and how to use the resources for the client's benefit.

Subp. 2. **Supervision of case manager.** Case managers with a bachelor's degree but without 2,000 hours of supervised experience in the delivery of services to persons with mental illness must complete 40 hours of training approved by the department in case management skills and in the characteristics and needs of persons with serious and persistent mental illness. Training in case management skills includes training in the delivery of services to persons with mental illness, the process of identifying and assessing a wide range of client needs, and the use of local community resources for a client's benefit. They must also receive clinical supervision regarding the provision of case management services from a mental health professional at least once a week including a face-to-face meeting of the case manager and the manager's clinical supervisor at least once a month until the requirement of 2,000 hours of supervised experience is met. Case managers who have at least 2,000 hours of supervised experience in the delivery of services to persons with mental illness shall meet in person with a mental health professional at least once a month to obtain clinical supervision of the case manager's activities. The dates and subjects discussed during the clinical supervision meetings must be documented in the client's record.

Subp. 3. **Training requirement.** A case manager must complete 30 hours of training every two years. The training must consist of in-service training or courses in areas related to mental health services such as mental health treatment, rehabilitation, prevention of mental illness, case management, licensing standards applicable to mental health services for persons with serious and persistent mental illness, child development, family relationships, and special needs of specific client populations or children. Training or courses must be approved by the case management provider.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

9505.0485 CASE MANAGER RESPONSIBILITIES.

Subpart 1. **Development of client's individual community support plan.** Within 30 days after the first meeting with a client, the case manager together with the client and, in the case of a child, except as provided in part 9505.0480, subpart 5, items A and B, the child's parent, legal representative, or primary caregiver, shall complete a written functional assessment and develop a written individual community support plan with the client based on the client's diagnostic assessment and needs. A review of the plan and the client's needs shall be completed at least every 90 days after the development of the first plan. A review of the functional assessment is to be completed at each review of the individual community support plan. To the extent possible and with the client's consent, the client, the client's family, physician, mental health providers, service providers, and other interested persons shall be involved in the development and implementation of the individual community support plan.

Subp. 2. **Contents of individual community support plan.** The individual community support plan must incorporate by specific reference the client's individual treatment plans, as they are developed. The client's individual treatment plans must be attached to the individual community support plan, which must be on a form supplied by the commissioner. The case manager shall ask the client to sign the completed individual community support plan as evidence that the case manager and the client have mutually agreed to the plan. The case manager must document a client's refusal to sign a completed individual community support plan. The individual community support plan must include at least the following information:

A. the goals of the client;

B. the services needed by the client;

C. the goals of each service;

D. the amount, scope, frequency, and duration of each service;

E. the frequency of face-to-face contact between the client and the case manager that is needed to implement the individual community support plan;

F. services involving a child's family or primary caregiver or a client's family or other interested persons; and

G. steps the client and the case manager will take to assure the client's access to services identified in the plan.

Subp. 3. **Referral, coordination, and monitoring.** The case manager shall refer the client to appropriate mental health or other service providers and offer to help the client gain access to needed services. In referring the client to appropriate mental health providers, the case manager shall also consider the client's need for referral for a neurological examination, psychological testing, and a chemical dependency assessment as specified in part 9530.6615. The case manager shall coordinate the provision of services to the client and monitor the client's progress to determine whether the goals of the individual community support plan are being met or progress toward the goals is taking place. If the case manager determines the goals, or progress toward the goals is not being met, the case manager together with the client shall modify the client's individual community support plan. The determination shall be made through regularly scheduled meetings and discussions with the client, the client's service providers, mental health providers, and the client's parents or legal representative if the client is a child. The coordination must include regularly scheduled meetings or contact with the client, the client's providers, and the case manager. If the client has coverage through a third party payer, the case manager shall help the client obtain payment for covered services. The case manager shall meet face to face with the client at least once every 30 days, unless the client receives case management services under subpart 6, refuses further case management services, or case management services are terminated as provided in part 9505.0489. In meeting with the client to carry out the purposes of this subpart, the case manager shall meet with the client at places other than the case manager's office building as necessary or appropriate to the client's need.

Subp. 4. **Emergency services.** If a case manager has reason to believe that a client may need or use emergency services under Minnesota Statutes, section 245.469, the case manager shall provide the client the information necessary for the client to access the emergency services. If the client has authorized a release of information as specified in part 9505.0482, the case manager shall inform providers of the emergency services and other mental health services of the client's possible need for and use of emergency services. Additionally, the case manager shall ask the emergency service to inform the case manager if the client requests emergency services and also to inform the case manager of the nature of and action taken in response to the client's request. The case manager is responsible for assuring that all persons needing to know about the client's use of emergency services are informed and for taking the lead in coordinating the use of emergency services and other mental health services. The case manager also is responsible for revising the client's individual community support plan as necessary to minimize the client's need for emergency services. If a client receives emergency mental health services, the mental health provider shall, with the client's consent, notify the case manager; however, the client's consent is not necessary if the emergency situation falls within the provisions of Minnesota Statutes, section 148.976, subdivision 1.

Subp. 5. **Records.** The case manager shall keep written records of the case manager's contacts with the client and other persons about the client's case. The

case management provider must retain the records for five years after the case manager's last contact with a client. The records must document:

A. each face-to-face contact with the client;

B. each telephone contact with the client, or any of the client's mental health providers or other service providers, a client's family members, primary caregiver, legal representative, or other interested persons or, if applicable, the reason the client's family members, primary caregiver, or legal representative was not contacted;

C. each face-to-face contact with a client's mental health or other service providers, a client's family, primary caregiver, legal representative, or other interested persons or, if applicable, the reason the client's family members, primary caregiver, or legal representative was not contacted;

D. each contact made with other persons interested in the client, such as representatives of the courts, corrections system, or schools;

E. the name of the person contacted;

F. the purpose and content of the contact;

G. the date and length of time spent in the contact;

H. any action agreed to regarding the client's case; and

I. supervisory meetings between the case manager and the case manager's clinical supervisor.

Subp. 6. **Case management services for clients outside the county of financial responsibility.** When a client is residing in or admitted to a residential treatment facility, regional treatment center, or inpatient hospital in a county other than the county of financial responsibility, case management services shall be provided either through telephone calls from the client's case manager to the client and to a representative of the facility, center, or hospital, or through face-to-face contact between the client and the case manager at least once every 30 days. Regardless of the frequency of telephone contact between the case manager and the client, the case manager shall meet with the client face-to-face at least once every 60 days. The case manager shall monitor the discharge planning process for the client and before or on the date of a planned discharge, the case manager shall meet face-to-face with the client. The case manager shall ask that a representative of the facility, center, or hospital notify the case manager of a planned discharge or if the client leaves against medical advice. Upon receiving notice that the client has left the facility, center, or hospital against medical advice, the case manager shall immediately attempt to locate the client. If the client returns to the county of financial responsibility, the case manager must have face-to-face contact with the client at least once every 30 days, with the client's consent.

Subp. 7. **Client's relocation.** When a client moves from the original county of financial responsibility to another county, the case management provider must provide copies of the client's case management records to the local agency in the new county of financial responsibility at the client's written request. The client's case management provider must notify the original county of financial responsibility of the client's relocation. The local agency in the new county of financial responsibility must help the client contact a case management provider in the county to which the client has moved, at the client's request, but need not provide notice as required in part 9505.0480, subpart 2.

Subp. 8. **Client's refusal to continue receiving case management services.** If a client refuses to continue receiving case management services or fails to contact the case manager face-to-face for more than 45 days, the client's case manager shall make a reasonable effort to contact the client no later than five days after the 45th day to determine if the client wants to continue receiving case management services. If the client can not be reached or wants to terminate case management services, the case manager shall notify the client and the local agency that case management services shall be terminated unless the client

contacts the case manager before the 60th day after the previous contact. The notice shall state the date of the previous contact and the date of the proposed termination. If the client does not respond by the 60th day, the case management services shall be terminated. A written notice sent to the client's last known address or another more effective means, known to and documented by the case manager, of contacting the client constitutes notice of termination of case management services.

If a former client wants to receive case management services again after a refusal or termination of services, the client may contact the case management provider directly and case management services must resume. The case management provider must notify the local agency when this occurs.

Subp. 9. **Case manager's caseload.** The local agency must establish the caseload of case managers on the basis of the requirements of parts 9505.0476 to 9505.0491. The local agency must require case management providers to document the amount of time each case manager spends on each client.

Subp. 10. **Case manager's provision of other mental health services.** A case manager shall not provide mental health services or other health services such as psychotherapy, day treatment services, residential treatment, medication management as specified in part 9505.0345, subpart 5, or independent living skills training to any client for whom the case manager is providing case management services.

A case manager may attempt to contact a potential case management client. However, these attempts do not qualify as case management services eligible for medical assistance payment under parts 9505.0476 to 9505.0491.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

9505.0486 REPORTING ABUSE OR NEGLECT OF VULNERABLE ADULT CLIENTS AND MALTREATMENT OF MINORS.

Subpart 1. **Vulnerable adults.** If a case manager knows or has reason to believe that a client who is a vulnerable adult is the subject of abuse or neglect, the case manager must immediately comply with the requirements of Minnesota Statutes, section 626.557, and determine how to assure the client's health and safety during the local agency's investigation. The case manager shall ask the local agency to inform the client of the findings of the local agency's investigation. When the case manager is informed of the findings of the local agency's investigation, the case manager shall work with the client to revise the client's individual community support plan as needed to assure the client's health and safety. For the purposes of this part, "vulnerable adult," "abuse," and "neglect" have the meanings given to them in Minnesota Statutes, section 626.557, subdivision 2.

Subp. 2. **Minors.** If a case manager knows or has reason to believe that a client who is a child has been neglected or physically or sexually abused within the preceding three years, the case manager shall immediately comply with the requirements of Minnesota Statutes, section 626.556, and assist in assuring the client's health and safety while the local agency conducts an assessment or investigation. The case manager shall ask the local agency to provide a summary of the local agency's disposition of any report made by the case manager. When the case manager receives the summary, the case manager shall work with the client to revise the client's individual community support plan as needed to assure the client's health and safety. For the purposes of this part, "neglect," "physical abuse," and "sexual abuse" have the meanings given them in Minnesota Statutes, section 626.556, subdivision 2.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

9505.0487 SERVICES NOT ELIGIBLE FOR MEDICAL ASSISTANCE AS CASE MANAGEMENT SERVICES.

The following services are not eligible for medical assistance payment as case management services:

A. diagnostic assessment;

B. administration and management of a client's medications;

C. legal services, including legal advocacy, for the client;

D. information and referral services that are part of a county's community social service plan as required under Minnesota Statutes, section 256E.09, subdivision 3;

E. outreach services through the community support services program;

F. services that are not documented as required under part 9505.0491, subpart 4, through records required in part 9505.0491, subpart 5; and

G. health services that are otherwise eligible for payment under Medicare, a third party payer, or parts 9505.0170 to 9505.0475, or other rules of the department. Examples are psychotherapy, psychological services, residential treatment, and medication management.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

9505.0488 CLIENTS' RIGHTS AND RESPONSIBILITIES.

In addition to the rights under Minnesota Statutes, section 144.651, clients receiving case management services have the following rights and responsibilities:

A. the right and responsibility to accept or refuse case management services;

B. the right and responsibility to accept or refuse services specified in the client's individual community support plan;

C. the right to request a change of case managers, and if the case management provider denies the client's request, the case management provider must document the reason for the denial in the client's case record;

D. the right to be referred to appropriate services specified in the client's individual community support plan;

E. the rights under the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13; and

F. the right to appeal under part 9505.0490.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

9505.0489 TERMINATION OF CASE MANAGEMENT SERVICES.

Case management services for a client terminate when one of the events listed in items A to E occurs. If one of the events listed in items A to E occurs, the case management provider shall notify the local agency. The local agency shall make a reasonable attempt to notify the client, before case management services are terminated under this part, and shall offer to refer the client to a mental health or other service provider appropriate to the client's needs. If the case manager is unable to locate the client, the case management provider shall notify the local agency and shall document the efforts to contact the client in the client's case record.

A. A mental health professional who has provided mental health services to the client furnishes a written opinion that the client no longer needs case management services.

B. The client and the case manager mutually decide that the client no longer needs case management services.

C. The client refuses to continue receiving case management services in the manner specified in part 9505.0485, subpart 8.

D. No face-to-face contact has occurred between the client and the client's case manager for 60 consecutive days unless the client is in a residential treatment facility, regional treatment center, or inpatient hospital in a county outside the county of financial responsibility.

E. No face-to-face contact has occurred between the client and the client's case manager for a period of 90 consecutive days because the client has failed to keep an appointment or refused to meet with the case manager and the client is in a residential treatment facility, regional treatment center, or inpatient hospital in a county outside the county of financial responsibility.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

9505.0490 APPEALS.

Subpart 1. **Right to appeal.** A person who applies for or receives case management services has the right to a fair hearing under Minnesota Statutes, section 256.045, as specified in subpart 3 in regard to termination, denial, suspension of payment for case management services, or a request or referral for case management services that is not acted upon within five days. A county of financial responsibility has an absolute defense to an appeal under this part if it proves by a preponderance of the evidence that it has no more resources available with which to avoid a denial, reduction, suspension, or termination of case management services to the person who applies for or receives case management services. The appeal rights of a person who applies for or receives case management services under parts 9505.0476 to 9505.0491, regardless of funding sources, are limited to those specified in this subpart.

Subp. 2. **Notice of adverse action.** The local agency shall mail a written notice to the person and the person's legal representative, if any, at least ten calendar days before denying, reducing, suspending, or terminating case management services. Except as provided in part 9505.0480, subpart 5, if the person is a child, the local agency must also send a copy of the notice to the child's parent or the child's primary caregiver. The written notice shall clearly state:

A. what action the local agency proposes to take;

B. the reason for the action;

C. the legal authority for the proposed action;

D. that the person has the right to appeal the action within 30 days after receipt of the notice or within 90 days if the person has good cause for delaying;

E. that case management services will not be reduced, suspended, or terminated if the person files an appeal before the date the action is taken; and

F. where and how to file an appeal.

Subp. 3. **General information about appeal rights.** At the time of the request for case management services and at any annual review of the individual community support plan that occurs, the case manager shall give the person, the person's legal representative, and, if the person is a child, the child's parent or primary caregiver, a written explanation of the person's right to appeal.

Subp. 4. **Commissioner's record of appeals.** The commissioner shall monitor the nature and frequency of appeals under this part.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

9505.0491 MEDICAL ASSISTANCE PAYMENT FOR CASE MANAGEMENT SERVICES.

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

A. "Face-to-face" means the client is physically present with the case manager.

B. "Unit" means an accumulation of time that totals 15 minutes in which case management services have been provided to or on behalf of a specific recipient or recipients.

Subp. 2. **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 client;

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

C. face-to-face contacts between the case manager and the client's family, legal representative, 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 concerning the client;

E. development, review, and revision of the client's individual community support plan, including the case manager's functional assessment of the client; and

F. time spent by the case manager traveling outside the county of financial responsibility to meet face-to-face with a client who is a resident of a regional treatment center, residential treatment facility, or an inpatient hospital that is located outside the county of financial responsibility.

Subp. 3. **Limitation on payments for services.** Payment for case management services shall be limited according to items A and B.

A. Payment for case management services is limited to no more than six hours per client per month, exclusive of travel, except under the conditions specified in item B. The payment may be for any combination of the services specified in subpart 2, except that payment for telephone contact between a case manager, the client, the client's legal representative, the client's family or primary caregiver, mental health providers, and other service providers, or other interested persons is limited to no more than two hours per client per month.

B. If the client is at risk of hospitalization, losing a job or place to live, or in danger of harming self or others because of the client's mental illness, the payment limitation on case management services to the client shall be ten hours per month, exclusive of travel. The payment limitation on telephone contact in item A shall apply to this item. In this instance, the case manager must document the factor or factors placing the client at risk.

C. A client's functional assessment by a case manager is eligible for medical assistance payment if the assessment does not duplicate a similar assessment of the client by the Division of Rehabilitation Services of the Minnesota Department of Jobs and Training.

Subp. 4. **Documentation required to receive medical assistance payment for case management services.** To receive medical assistance payment for case management services the case manager must document the case management services provided and the time spent in providing them. Case management providers must maintain records as required under part 9505.0205 and comply with the applicable provisions of parts 9505.1750 to 9505.2150.

Subp. 5. **Charting, record keeping, and travel.** Time spent by the case manager in charting, record keeping, and traveling within the county of financial responsibility is not eligible for separate medical assistance payment as a case management service.

Subp. 6. **Billing by units.** A case management provider shall bill for medical assistance payment for eligible case management services provided to a recipient according to units of service provided, as defined in subpart 1, and documented as required in subpart 4.

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. **Termination of payment.** Medical assistance payment for case management services terminates when the case manager notifies the local agency that one of the events in part 9505.0489 has occurred.

Subp. 10. **Recovery of payment.** Medical assistance payments received by a case management provider for case management services that are not documented as required in subpart 4 are subject to recovery under parts 9505.1750 to 9505.2150.

Statutory Authority: *MS s 245.461 to 245.486; 256B.0625 subd 20*

History: *13 SR 1439*

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 20.

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 serv-

ices 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*

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 admission certification prior to the recipient's admission in order for the admitting physician, the hospital, or other vendor of an inpatient hospital service to receive medical assistance or general assistance medical care program payment for the inpatient hospital service.

Subp. 2. **Exclusions from admission certification or prior admission certification.** Admission for inpatient hospital services under items A 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 9505.1750 to 9505.2150.

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 9505.1750 to 9505.2150.

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 9505.1750 to 9505.2150.

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 9505.1750 to 9505.2150. 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 9505.1750 to 9505.2150.

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, Ford Building, 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 9500.1130, subpart 7, item A, 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 9500.1130, subpart 7, item A, 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 9500.1130, subpart 7, item A, 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*

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 him or his spouse from private health care coverage or the Minnesota no-fault auto insurance law to the costs of medical care for himself, his spouse, and legal dependents. The local agency or the department may require from any applicant or recipient of general assistance medical care the assignment of any rights accruing under such health and accident care coverage. Any rights or amounts so assigned shall be applied against the cost of medical care paid for by the general assistance medical care program.

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

History: *12 SR 1148*

9505.1040 APPLICATION FOR GENERAL ASSISTANCE MEDICAL CARE.

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

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

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

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

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

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

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

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

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

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

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

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

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

CATASTROPHIC HEALTH EXPENSE PROTECTION

9505.1100 SCOPE AND STATUTORY AUTHORITY FOR CHEPP.

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

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

9505.1110 PERSONS REGULATED.

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

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

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

9505.1120 UNIFORM IMPLEMENTATION.

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

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

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

9505.1130 CIVIL RIGHTS PROTECTIONS.

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

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

9505.1140 SUBORDINATION OF RULES TO STATE AND FEDERAL LAWS.

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

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

9505.1150 DEFINITIONS.

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

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

Subp. 3. **Applicant.** "Applicant" means a person who has directly, or through his attorney, guardian, or personally designated representative, made application for benefits from the CHEP program with his local welfare agency. Additionally, an applicant may be a deceased person's estate, on behalf of which an application is filed by the personal representative of the estate, subject to the restrictions in part 9505.1160, subpart 2.

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

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

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

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

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

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

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

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

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

(1) 40 percent of his household income up to $15,000, plus 50

percent of his household income between $15,000 and $25,000, plus 60 percent of his household income in excess of $25,000; or

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

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

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

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

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

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

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

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

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

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

Subp. 19. **Medical assistance program.** "Medical assistance program" means that program of medical assistance to the poor and needy established by title XIX

of the federal Social Security Act as of July 1, 1977, and, in Minnesota, by Minnesota Statutes, chapter 256B.

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

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

Subp. 22. **Nursing home.** "Nursing home" means an institution which is licensed as a nursing home by the state in which it is located. The term includes facilities which meet the standards of the Minnesota medical assistance program for enrollment as skilled nursing facilities or as intermediate care facilities (I), but it excludes facilities (or beds, in the case of multilevel facilities) which are classified as intermediate care facilities (II) or as intermediate care facilities (mental retardation 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 his dependents actually paid or contributed toward the insurance premiums, the contributions were made during the deductible period, and the services for which the insurance payments were made were received during the deductible period.

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

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

Subp. 26. **Private health care coverage.** "Private health care coverage" means any plan regulated by Minnesota Statutes, chapters 62A, 62C, 62D, or 64A, or sections 62E.01 to 62E.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 his direction;

C. drugs requiring a physician's prescription;

D. services of a skilled nursing facility which meets the requirements for participation as such in the medicare program or the medical assistance program, for not more than 120 days in an individual eligible person's year-long eligibility period, if the services would qualify as reimbursable services under medicare, and if the services do not fall into the class of "qualified nursing home expenses" defined in subpart 29, and if, in addition, the patient's attending physician certifies in writing that the services are not primarily of a custodial or residential nature;

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

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

G. oxygen;

H. anesthetics;

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

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

K. diagnostic X-rays and laboratory tests;

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

M. services of a physical therapist; and

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

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

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

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

Subp. 32. **Resident of Minnesota.** "Resident of Minnesota" means a person who is presently residing in Minnesota, having there his principal and permanent abode, and having no intent to return to some other state to live upon completion of a course of medical care. In deciding whether an applicant for CHEPP benefits is a resident of Minnesota, all important aspects of the applicant's situation shall

be considered, and the decision shall be made on the preponderance of the evidence. In doubtful cases, the following forms of evidence of residence may be included in those examined:

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

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

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

(1) registered to vote;

(2) licensed to drive;

(3) registering their car(s);

(4) claiming a homestead for property tax relief;

(5) employed;

(6) doing their banking; and

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

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

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

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

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

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

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

History: *L 1984 c 654 art 5 s 58; 12 SR 1148; L 1987 c 384 art 2 s 1*

9505.1160 APPLICATION.

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

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

9505.1170 DELEGATION OF AUTHORITY.

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

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

9505.1180 PROVISION OF INFORMATION BY LOCAL WELFARE AGENCIES.

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

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

9505.1190 CONSIDERATION OF ALTERNATIVE WELFARE PROGRAMS.

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

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

9505.1200 INFORMATION AND DOCUMENTS TO BE SUPPLIED BY CHEPP APPLICANTS.

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

A. Application data:

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

(2) birthdates of all family members;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9505.1210 CHEPP DEDUCTIBLE.

The CHEPP deductible is out-of-pocket. Eligible expenses offered in satisfaction of the CHEPP deductible must be out-of-pocket expenses and/or liabilities as defined in part 9505.1150, subpart 23. Eligible expenses attributed to the CHEPP deductible need not have been paid in advance of CHEPP eligibility, and failure of an applicant to pay them shall not affect the applicant's eligibility. Payment of such deductible expenses by relatives, friends, or other persons having no legal duty to pay shall not defeat the out-of-pocket character of the expenses. If a payment by a liable third party is not available within a reasonable period of time (normally 120 days from the date of application), and if the applicant cannot otherwise qualify for the CHEP program, the charges whose payment is in question may be treated as eligible expenses for satisfaction of the CHEPP deductible, provided all required assignments of benefits are signed by the member of the applicant family who appears to be entitled to the delayed or disputed third party payment.

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

9505.1220 SATISFACTION OF THE CHEPP DEDUCTIBLE.

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

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

9505.1230 INCOME CONSIDERED IN SPECIAL CASES.

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

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

9505.1240 DURATION OF ELIGIBILITY.

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

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

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

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

9505.1250 ELIGIBILITY FOR PAYMENT OF QUALIFIED NURSING HOME EXPENSES.

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

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

9505.1260 APPLICATION FOR PAYMENT OF QUALIFIED NURSING HOME EXPENSES.

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

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

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

9505.1270 TERMINATION OF ELIGIBILITY.

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

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

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

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

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

9505.1280 APPEALS.

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

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

9505.1290 BENEFITS PAYABLE.

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

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

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

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

= Eligible person's raw entitlement

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

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

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

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

9505.1300 FORGIVENESS OF DISALLOWED CHARGES.

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

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

section of that facility for that level of care of the Minnesota medical assistance program.

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

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

9505.1310 PERSONS TO WHOM PAYMENTS ARE MADE.

CHEPP 1 benefits shall be paid only to providers of health services, and then only after receipt of a proper billing for review and adjudication; provided, however, that benefits shall be paid to eligible persons directly if the eligible person has already paid the provider and the services were received before the date of the eligible person's application for CHEPP. CHEPP 2 benefits shall be paid to the eligible nursing home resident or on his behalf to his spouse or guardian.

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

9505.1320 POSTPAYMENT ADJUSTMENTS.

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

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

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

9505.1330 ENROLLMENT OF REGULAR PROVIDERS.

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

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

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

9505.1340 INVOICING PROCEDURES.

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

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

Subp. 3. **Prohibition to providers.** Providers who bill the CHEP program shall accept the program's determination of what will constitute reasonable charges for services to CHEPP beneficiaries, and they shall not attempt to collect from

beneficiaries any charges disallowed by the program as excessive or as being for services deemed not medically necessary.

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

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

9505.1350 THIRD PARTY INSURANCE CLAIMS.

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

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

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

9505.1360 CHEPP BENEFICIARY IDENTIFICATION CARDS.

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

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

9505.1370 NONQUALIFYING EXPENSES.

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

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

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

C. Transsexual surgery.

D. Artificial insemination.

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

F. Autopsies.

G. Missed appointments.

H. Costs of billing.

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

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

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

9505.1380 TERMINATION OF PROVIDER ENROLLMENTS.

Providers may be terminated from enrollment as eligible payees under the CHEP program according to the procedures established for such termination in

the Minnesota medical assistance program. Providers terminated from the medical assistance program for misconduct shall be simultaneously terminated from the CHEP program.

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

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. 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 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

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 317;

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*

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 9505.1750 to 9505.2150.

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, and chemical abuse.

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.** The Denver Prescreening Developmental Questionnaire (PDQ) or the Denver Developmental Screening Test (DDST) must be administered to a child under six years of age. The DDST must be administered to a child whose score on the PDQ is below the age norms for that test. The provider may use an alternative developmental screening test in place of the PDQ or DDST, if approval of the alternative test is given by the department in writing. The alternative test must be standardized, must have norms for the age range tested, and must have written procedures for its administration, scoring, and interpretation.

A child six to 20 years of age 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, and cognitive development.

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," June 1988. 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," June 1988, is developed and distributed by the Minnesota Department of Health, 717 Delaware Street, Minneapolis, Minnesota 55440. The "Recommended Schedule for Active Immunization of Normal Infants and Children," June 1988, is incorporated by reference and is available at the State Law Library, Ford Building, 117 University Avenue, Saint Paul, Minnesota 55155. It is not 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. An erythrocyte protoporphyrin (EP) test must be done for a child whose physical examination under subpart 4 indicates possible lead toxicity; and for a child age nine months to six years whose health history indicates that the child:

(1) has lived in or frequently visited houses built before 1950;

(2) has shared the residence of a parent or other person who participates in a lead-related occupation or hobby;

(3) has lived near roadways with heavy traffic, hazardous waste sites, lead smelters, or processing plants;

(4) has a sibling or playmate known to have lead toxicity; or

(5) is at risk of possible exposure to lead through the use of folk medicines.

If an EP test is elevated above the level of 35 micrograms of lead per deciliter of whole blood, the child must be referred for further testing.

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. 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 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	7-11 months
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
Development:					
PDQ/DDST			X	X	X
Sexual Development	X	X	X	X	X
Nutrition	X	X	X	X	X
Immunizations		X	X	X	X
Laboratory Tests:					
Tuberculin		if history indicates			
Lead Absorption		if history indicates			
Urine	←	←	←	X	←
Bacteriuria (females)					
Anemia					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.

B. Early Childhood:

Standards	Ages		
	12-15 months	16-19 months	20-35 months
Health History	X	X	X
Assessment of Physical Growth:			
Height	X	X	X

Weight	X	X	X
Head Circumference	X	X	X
Physical Examination	X	X	X
Vision	X	X	X
Hearing	X	X	X
Development:			
PDQ/DDST	X	X	X
Sexual Development	X	X	X
Nutrition	X	X	X
Immunizations	X	X	X
Laboratory Tests:			
Tuberculin	if history indicates		
Lead Absorption	if history indicates		
Urine	←	←	X
Anemia	←	←	←
Sickle Cell	at parent's or child's request		
Other Laboratory Tests	as indicated		
Oral Examination	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			
	3-4 years	5-7 years	8-10 years	11-13 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
Development:				
PDQ/DDST	X	X		
Fine & Gross Motor, Speech & Language, Social, Cognitive		X	X	X
Sexual Development	X	X	X	X
Nutrition	X	X	X	X
Immunizations	X	X	X	X
Laboratory Tests:				
Tuberculin	if history indicates			
Lead Absorption	if history indicates			
Urine	←	←	X	←

Bacteriuria (females)	X	←	X	←
Anemia	←	←	X	←
Sickle Cell	at parent's or child's request			
Other Laboratory Tests	as indicated			
Oral Examination	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 14-17 years	Ages 18-20 years
Health History	X	X
Assessment of Physical Growth:		
Height	X	X
Weight	X	X
Physical Examination	X	X
Vision	X	X
Hearing	X	X
Development:		
PDQ/DDST		
Fine & Gross Motor, Speech & Language, Social, Cognitive	X	X
Sexual Development	X	X
Nutrition	X	X
Immunizations	X	X
Laboratory Tests:		
Tuberculin	if history indicates	
Lead Absorption	if history indicates	
Urine	←	X
Bacteriuria (females)	←	←
Anemia	←	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.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

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 or a community health clinic 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.

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 January 1 of each year in which the contract will be effective. A contract must contain items A to K 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 local public health nursing service or the community health clinic will provide program and fiscal records 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. names of the skilled professional medical personnel and their supporting staff;

J. methods by which the local agency will monitor and evaluate the contract; and

K. signatures of the representatives of the contracting parties and dates of those signatures.

Statutory Authority: *MS s 256B.04 subd 2; 256B.0625 subd 14*

History: *13 SR 1150*

SURVEILLANCE AND UTILIZATION REVIEW PROGRAM

9505.1750 DEFINITIONS.

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

Subp. 2. **Abuse.** "Abuse" means a pattern of practice by a provider, or a pattern of health care utilization by a recipient which is inconsistent with sound fiscal, business, or medical practices, and results in unnecessary costs to the programs, or in reimbursements for services that are not medically necessary or

that fail to meet professionally recognized standards for health care. Abuse is characterized by, but not limited to, the presence of one of the following conditions:

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

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

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

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

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

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

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

H. The recipient permitting the use of his/her medical identification card by any unauthorized individual for the purpose of obtaining health care through any of the programs.

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

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

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

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

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

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

Subp. 7. **Medical record.** "Medical record" means written documentation of the nature, extent, and evidence of the medical necessity of health care provided

to program recipients by or under the authority of a medical doctor and billed to the programs.

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

A. provided in response to life threatening conditions;

B. provided in response to pain;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9505.1760 PURPOSE.

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

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

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

9505.1770 STATUTORY AUTHORITY.

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

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

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

9505.1780 BULLETINS, MANUALS, AND FORMS.

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

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

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

9505.1790 SCOPE.

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

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

9505.1800 MEDICAL AND HEALTH CARE RECORDS.

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

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

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

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

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

C. Diagnoses, assessments, or evaluations.

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

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

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

G. The results of all diagnostic tests and examinations.

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

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

J. Dates of hospitalization relating to service provided by a particular provider.

K. A copy of the summary of surgical procedures billed to the programs by the provider.

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

9505.1810 RECORDS EXCEPTION.

Subpart 1. **Applicability.** The requirements of item C shall not apply to pharmacies, laboratories, ambulance services, and medical transportation providers, or suppliers of medical equipment and nondurable supplies.

Subp. 2. **Records required.** For the purpose of parts 9505.1750 to 9505.2150, provider groups mentioned in this part shall develop and maintain the following records:

A. Pharmacies:

(1) Prescriptions or equivalent computer record.

(2) This part shall not require the development and maintenance of a recipient drug profile; however, if available, the state agency shall be authorized to review such a record.

B. Laboratories:

(1) Documentation of provider orders for laboratory tests or procedures.

(2) Documentation of test results.

C. Ambulance service and medical transportation providers:

(1) Documentation of physician authorization for nonemergency medical transportation.

(2) Trip tickets.

(3) Documentation of durable and nondurable supplies expended on a recipient.

D. Suppliers of medical equipment and nondurable supplies:

(1) Prescriptions.

(2) Documentation of physician orders related to the provision of equipment and supplies.

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

9505.1820 FINANCIAL RECORDS.

Subpart 1. **Requirement.** Financial records pertaining to the provider's costs, if the provider is reimbursed on a cost basis, and charges for health care provided to program recipients shall be developed and maintained.

Subp. 2. **Contents of records for all providers.** Financial records for all providers, other than nursing homes and board and care homes certified by the Department of Health, shall include:

A. purchase invoices;

B. all accounting records including, but not limited to, payroll ledgers, canceled checks, and bank deposit slips;

C. all contracts for supplies and services which relate to the provider's costs and charges for health care billed to the programs;

D. evidence of the provider's usual and customary charges and written evidence of charges to nonrecipient patients without violating nonrecipient patient rights to confidentiality; and

E. evidence of claims for reimbursement, payments, settlements, or denials resulting from claims submitted to other third party payers of health care.

For the purposes of parts 9505.1750 to 9505.2150, third parties shall include other governmental programs, insurance companies, no-fault auto insurers, and other payers of health care who may be financially responsible for services rendered a recipient.

Subp. 3. **Contents of records for nursing homes and board and care homes.** Financial records for nursing homes and board and care homes certified by the Department of Health, shall include all records identified in subpart 2 and records of deposits and expenditures for patient personal needs allowance accounts.

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

9505.1830 ACCESS TO RECORDS.

For the purposes of parts 9505.1750 to 9505.2150, as set forth in part 9505.1760, providers shall grant the state agency access during regular business hours to examine medical, health care, and financial records related to health care billed to the programs. Access to a recipient's personal medical and health care record shall be for the purpose of investigating whether or not a provider has submitted a claim for reimbursement, a cost report, or a rate application which may be false in whole or in part or whether or not the health care was medically necessary. The SUR section shall notify the provider at least 24 hours before gaining access to such records. Upon the request of the provider, the SUR section shall present a copy of the recipient's written authorization to examine personal medical records unless the provider already has received written authorization from the recipient. A provider's refusal to grant the state agency access to examine records when authorized shall be grounds for sanction.

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

9505.1840 COPYING RECORDS.

The state agency, at its own expense, is authorized to photocopy or otherwise duplicate any medical or financial record which it is authorized to examine. Photocopying shall be limited to the provider's premises unless removal is specifically permitted by the provider.

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

9505.1850 RETENTION OF RECORDS.

Providers shall retain all records for at least five years. Records may be microfilmed after the third year.

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

9505.1860 CHANGE OF OWNERSHIP.

In the event of a change of ownership of a facility or practice the seller, unless otherwise provided by law or by written agreement, shall be responsible for maintaining and preserving all records generated prior to the date of sale. Responsibility for making records available for inspection after the date of sale is on the seller and the seller must take reasonable steps by contract or otherwise to maintain a right of access to those records which is necessary to substantiate his billings, cost reports, or rate applications.

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

9505.1870 PROVIDER WITHDRAWAL OR TERMINATION.

In the event a provider withdraws or is terminated from the programs, all records developed during participation in the programs, and not subject to the provisions of part 9505.1860, shall be retained by the provider for a period of five years and shall be available for review by the state agency. Providers must retain records for at least five years after the date of billing.

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

9505.1880 RECIPIENT CONSENT TO REVIEW OF RECORDS.

A recipient's consent to the state agency's review of his or her medical or health care records shall be presumed competent if given in conjunction with an application for coverage under the programs. This presumption shall be rebuttable, and shall exist regardless of whether the application was signed by a recipient or a guardian.

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

9505.1890 IDENTIFICATION OF SUSPECTED FRAUD AND ABUSE.

Subpart 1. **Duties of SUR.** SUR shall be responsible for the detection and identification of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by providers who have billed the programs for health care rendered to a recipient.

Subp. 2. **Authorization to use information.** For the purposes of parts 9505.1750 to 9505.2150, SUR shall be authorized to utilize information from sources which shall include, but not be limited to:

A. units of local, state, and federal government;

B. other third-party payers including health insurance carriers;

C. professional standards review organizations;

D. citizens, including recipients;

E. providers, professional associations, and health care professionals; and

F. computer reports generated by MMIS, using claim data to develop profiles on the provision and utilization of health care reimbursed by the programs. The profiles compare data on a peer group basis, and identify providers and recipients who appear exceptional when compared to group norms.

Subp. 3. **Assessment and consultation.** In assessing questions of abuse or medical necessity, SUR shall consult with a review organization as defined in Minnesota Statutes, section 145.61 or other provider advisory committees as appointed by the commissioner.

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

9505.1900 INVESTIGATION OF SUSPECTED FRAUD OR ABUSE BY PROVIDERS.

Subpart 1. **Duties of SUR.** SUR shall be responsible for the investigation of suspected fraud and abuse identified pursuant to part 9505.1890. An investigation shall be conducted for the purposes of determining one or more of the following:

A. whether the suspected aberrant activity of a provider is the result of a legitimate condition of practice;

B. whether suspected fraud and abuse exists and can be documented;

C. whether sufficient evidence can be developed to support administrative, civil, or criminal action as to such fraud and abuse.

Subp. 2. **The investigation.** A SUR investigation may include, but is not limited to:

A. examination of records pursuant to parts 9505.1800 to 9505.1880;

B. interviews of providers, their associates, and employees;

C. interviews of program recipients;

D. verification of the professional credentials of providers, their associates, and employees;

E. examination of any equipment, stock, materials, or other items used in or for the treatment of program recipients;

F. examination of prescriptions written for program recipients; and

G. determination of whether the health care provided was medically necessary.

Subp. 3. **Postinvestigation action.** Following the completion of an investigation, SUR shall take one or more of the following actions:

A. determine that no further action is warranted and so notify the provider;

B. impose administrative sanctions against a provider in accordance with part 9505.1910;

C. seek monetary recovery from a provider as set forth in part 9505.1910; and

D. refer the case in writing to the attorney general for possible civil or criminal legal action.

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

9505.1910 MONETARY RECOVERY AND SANCTIONS AGAINST PROVIDERS.

The commissioner shall be authorized to seek monetary recovery or impose administrative sanctions to protect the public welfare and the interests of the program. Monetary recovery and sanctions implemented by the commissioner shall be based upon documentation of fraud and abuse as set forth in parts 9505.1890 and 9505.1900.

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

9505.1920 GROUNDS FOR MONETARY RECOVERY FROM PROVIDERS.

The commissioner may seek monetary recovery against providers for any of the following:

A. fraud, theft, or abuse in connection with health care services billed to the programs;

B. presentment of false or duplicate claims, or claims for services not medically necessary; and

C. false statement of material facts for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

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

9505.1930 GROUNDS FOR IMPOSITION OF ADMINISTRATIVE SANCTIONS AGAINST PROVIDERS.

The commissioner may impose administrative sanctions against providers for any of the following:

A. fraud, theft, or abuse in connection with health care services billed to the program;

B. a pattern of presentment of false or duplicate claims or claims for services not medically necessary;

C. a pattern of making false statement of material facts for the purpose of obtaining greater compensation than that to which the provider is legally entitled; and

D. refusal to grant the state agency access to records pursuant to part 9505.1830.

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

9505.1940 EFFECT OF FRAUD OR ABUSE OF MEDICARE PROGRAM.

The commissioner shall suspend or terminate any provider who has been suspended or terminated from participation in the medicare program because of fraud or abuse in connection with the title XVIII of the Social Security Act.

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

9505.1950 METHODS OF MONETARY RECOVERY FROM PROVIDERS.

The commissioner shall make monetary recovery from providers of moneys erroneously paid due to violations described in part 9505.1920 by the following means:

A. permitting voluntary repayment by the provider of moneys erroneously paid, either in lump sum payment or installment payments;

B. withholding of payments;

C. debiting from program payments, moneys determined to have been erroneously paid; and

D. using any legal process to collect such moneys.

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

9505.1960 USE OF RANDOM SAMPLE EXTRAPOLATION.

Subpart 1. **Authorization.** For the purpose of part 9505.1950, the commissioner shall be authorized to make monetary recovery from providers of moneys erroneously paid, based upon extrapolation from systematic random samples of claims submitted by a provider and paid by the programs.

Subp. 2. **Decision to use samples.** The decision to use sampling and extrapolation in calculating a monetary recovery shall be at the discretion of the director of the SUR section. The following criteria shall apply in determining whether the sampling technique will be used:

A. the claims to be sampled represent services to 50 or more recipients; or

B. there are more than 1,000 claims to be sampled; or

C. the claims to be sampled constitute charges to the department of more than $2,000.

Subp. 3. **Sampling method.** The following factors shall apply in determining recovery by sampling and extrapolation:

A. Samples shall be selected such that every claim to be sampled has an equal and independent chance of being chosen for the sample.

B. Samples shall only be selected from claims within a time period which coincides with the duration of the violations for which recovery will be made.

C. The sampling method, to include sample size, sample selection, and extrapolation from the results of the sample, shall be in accordance with statistical procedures published in the following texts: L. Kish, Survey Sampling, John Wiley and Sons, New York (1965), or W. Cochran, Sampling Techniques, John Wiley and Sons, New York 3rd Ed. (1977).

D. Samples shall be selected at the 95 percent confidence level, such that, the overall monetary recovery amount determined by extrapolation from the sample recovery amount will be within five percent of the amount which would be recovered by a complete audit, 95 percent of the time. The department will recover the extrapolated amount less the five percent factor.

Subp. 4. **Notice of intent to use samples.** The department shall notify the provider of its intent to use sampling and extrapolation. The notice shall state

the nature of claims to be sampled, the sample size, the sample selection method, and the formulas and calculators to be used in extrapolation.

Subp. 5. **Rebuttable sampling results.** The monetary recovery proposed by the department, based upon the use of sampling and extrapolation is rebuttable. The provider may present, at a conference with the SUR director, material to rebut the sample size and design, the facts and conclusions drawn from each sample used, and the calculations used to extrapolate the sample findings to all services furnished for the period of time reviewed. The costs of gathering and presenting the information will be met by the provider. Alternatively, the provider, at his expense, may conduct a complete audit and use the results to rebut the department's findings.

Subp. 6. **Appeal procedure.** If the department does not accept the provider's rebuttal, the provider may appeal under procedures cited at part 9505.2150.

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

9505.1970 SANCTIONS AGAINST PROVIDERS.

The commissioner may impose any of the following sanctions for the conduct described in part 9505.1930:

A. referral to the appropriate state regulatory agency;

B. referral to the appropriate peer review mechanism;

C. transfer to a provider agreement of limited duration not to exceed 12 months;

D. transfer to a provider agreement which stipulates specific conditions of participation; and

E. suspending or terminating participation.

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

9505.1980 NOTICE TO PROVIDERS OF AGENCY ACTION.

Subpart 1. **Requirement.** The state agency shall notify providers in writing of any recovery of money or sanction it intends to impose.

Subp. 2. **Contents.** The notice shall state:

A. the factual basis for alleging discrepancies or violations;

B. the dollar value to such discrepancies or violations;

C. how such dollar value was computed;

D. what actions the state agency intends to take;

E. the provider's right to dispute the state agency's factual allegations and to provide evidence to support the provider's position; and

F. the provider's right to appeal the state agency's proposed action pursuant to part 9505.2150.

Subp. 3. **Effective date of recovery or sanction.** The effective date of the proposed monetary recovery or sanction shall be at least 20 calendar days following receipt of certified mail notifying the provider of the proposed action. If the provider appeals pursuant to part 9505.2150, the action shall not be implemented until the commissioner's order is issued following the hearing on appeal, provided that the suspending or withholding of payment shall be effective on the date the notice is received, if in the commissioner's opinion such action is necessary to protect the public welfare and interests of the program. However, the commissioner shall not order a prehearing suspension or withholding of payments to a nursing home or board and care home. Implementation of a proposed action following the hearing on appeal may be postponed if in the opinion of the commissioner the delayed action is necessary to protect the welfare or interests of program recipients.

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

9505.1990 COMMISSIONER TO DECIDE IMPOSITION OF SANCTION AGAINST PROVIDER.

The decision as to the sanction to be imposed against a provider, pursuant to part 9505.1930, shall be at the discretion of the commissioner. The following factors shall be considered in determining the sanctions to be imposed:

A. nature and extent of offenses or violations;

B. history of prior violations;

C. provider's willingness to obey program rules; and

D. actions taken or recommended by other state regulatory agencies.

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

9505.2000 SUSPENSION OR TERMINATION OF PROVIDER PARTICIPATION.

Suspension or termination from participation shall preclude a provider from submitting any claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association for any health care provided under the programs, except for health care provided prior to the suspension or termination.

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

9505.2010 PROHIBITED SUBMISSION OF PROVIDER'S CLAIMS.

No clinic, group, corporation, or other association which is a provider of services shall submit any claim for payment for any health care provided by an individual provider within such organization who has been suspended or terminated from participation in the programs, except for health care provided prior to the suspension or termination. The state agency shall seek monetary recovery of such claims. Knowing submission of such claims shall be a ground for administrative sanction.

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

9505.2020 AGENCY NOTICE OF PROVIDER'S SANCTIONS.

When a provider has been sanctioned in accordance with part 9505.1960, after all appeals have been exhausted or the time in which to file an appeal has elapsed, the state agency shall notify the appropriate professional society, board of registration or licensure, and federal or state agencies of the findings made, sanctions imposed, appeals made, and the results of any subsequent appeal.

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

9505.2030 MONEY RECOVERY AND SANCTIONS AGAINST PROVIDERS.

Nothing in parts 9505.1750 to 9505.2150 shall prevent the commissioner from simultaneously seeking monetary recovery and imposing sanction against a provider.

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

9505.2040 ROUTINE AUDITS OF PROVIDERS.

Nothing in parts 9505.1750 to 9505.2150 shall prohibit SUR from conducting routine audits of providers in order to monitor compliance with program requirements.

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

9505.2050 SUSPENSION OR WITHHOLDING OF PAYMENTS TO PROVIDERS PRIOR TO A HEARING.

The commissioner is authorized to suspend or withhold payments to a provider prior to a hearing, as provided in part 9505.1980, subpart 3, if:

A. there is a substantial likelihood of prevailing in an action pursuant to parts 9505.1910 to 9505.2040; or

B. there is a substantial likelihood that the provider's pattern of practice which prompted a SUR investigation, will continue in the future; or

C. there is reasonable cause to doubt a provider's financial ability to refund any amounts determined to be due the program.

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

9505.2060 FEDERAL LAW PREVAILS.

To the extent that federal law or regulation mandates sanctions against providers or recipients which conflict with provisions of parts 9505.1750 to 9505.2150, such federal law or regulation shall prevail.

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

9505.2070 IDENTIFICATION OF SUSPECTED FRAUD AND ABUSE BY RECIPIENTS.

Subpart 1. **Duties of SUR.** SUR shall be responsible for the detection and investigation of suspected fraud, theft, or abuse by recipients of the programs.

Subp. 2. **Information available.** For the purpose of parts 9505.1750 to 9505.2150, SUR shall be authorized to utilize at least the sources of information identified in part 9505.1890, subpart 2.

Subp. 3. **Assessment of medical necessity.** In assessing the question of medical necessity, SUR shall consult with a review organization as defined in Minnesota Statutes, section 145.61 or other provider advisory committees as appointed by the commissioner.

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

9505.2080 INVESTIGATION OF SUSPECTED FRAUD AND ABUSE BY RECIPIENTS.

SUR shall be responsible for the investigation of suspected fraud and abuse identified pursuant to part 9505.2070. A SUR investigation shall be conducted for the purpose of determining:

A. whether suspected fraud, theft, or abuse exists and can be documented;

B. whether sufficient evidence can be developed to support restricting recipient participation in the programs in accordance with parts 9505.2090 to 9505.2140; and

C. whether sufficient evidence exists to support the imposition of other sanctions in accordance with parts 9505.2090 to 9505.2140.

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

9505.2090 GROUNDS FOR SANCTIONS AGAINST RECIPIENTS.

SUR may impose administrative sanctions against program recipients for any of the following:

A. altering or duplicating the medical identification card in any manner;

B. permitting the use of his or her medical identification card by any unauthorized individual for the purpose of obtaining health care through the programs;

C. using a medical identification card that belongs to another person;

D. using the medical identification card to assist any unauthorized individual in obtaining health care for which the programs are billed;

E. duplicating or altering prescriptions;

F. knowingly misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, or drugs;

G. knowingly furnishing incorrect eligibility status or information to a provider;

H. knowingly furnishing false information to a provider in connection with health care previously rendered which the recipient has obtained and for which the programs have been billed;

I. knowingly obtaining health care in excess of established program limitations, or knowingly obtaining health care which is clearly not medically necessary;

J. knowingly obtaining duplicate services from a multiple number of providers for the same health care condition, excluding confirmation of diagnosis; or

K. otherwise obtaining health care by false pretenses.

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

9505.2100 SANCTIONS AGAINST PROGRAM RECIPIENTS.

SUR may impose any of the following sanctions for the conduct described in part 9505.2090:

A. referring the recipient for appropriate health counseling in order to correct inappropriate or dangerous utilization of health care;

B. referring the recipient to the attorney general for possible criminal or civil legal action;

C. recovery from recipients, to the extent permitted by law all amounts incorrectly paid by the programs;

D. terminating participation for that period during which a potential recipient refuses to sign a consent for release of records; or

E. restricting the recipient's participation in a program to receiving health care from a provider whom the recipient has had the opportunity to select.

The restriction shall be for a specified period of time and all changes in the designation of a provider during the restriction period shall be approved by the state agency. Reimbursement for nonemergency health care shall be limited to the designated provider.

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

9505.2110 NOTICE TO RECIPIENTS OF SANCTIONS.

The state agency shall cause the recipients to be notified in writing of any sanction it intends to impose.

The notice shall state:

A. the factual basis for alleging discrepancies or violations;

B. the dollar value to such discrepancies or violations;

C. how such dollar amount was computed;

D. what actions the state agency intends to take;

E. the recipient's right to dispute the state agency's factual allegations; and

F. the recipient's right to appeal the state agency's proposed action pursuant to part 9505.2150.

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

9505.2120 REIMBURSEMENT FOR EMERGENCY HEALTH CARE OF A RESTRICTED RECIPIENT.

Emergency health care provided a restricted recipient by any provider shall be eligible for reimbursement by the programs if the claim for reimbursement is accompanied by a full explanation of the emergency circumstances.

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

9505.2130 SPECIALIZED HEALTH CARE OF RESTRICTED RECIPIENT.

The programs shall pay for specialized health care provided a restricted recipient if a copy of the written referral by the recipient's chosen provider is sent to the SUR section.

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

9505.2140 RESTRICTION TO BE INDICATED ON MEDICAL CARD.

The fact that a recipient is restricted shall be clearly indicated on the medical card.

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

9505.2150 APPEAL OF AGENCY ACTIONS.

Subpart 1. **Provider's right to appeal.** A provider may appeal the state agency's proposed administrative sanction, proposed suspension or withholding of payment, or demand for monetary recovery against a provider pursuant to the provisions of Minnesota Statutes, sections 14.57, 14.58, and 14.59 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner within 20 days of the date notice is received pursuant to part 9505.1980.

Subp. 2. **Recipient's right to appeal.** A recipient may appeal any sanction proposed by the state agency pursuant to the provisions of Minnesota Statutes, section 256.045.

Subp. 3. **Informal discussion of issues.** Nothing in parts 9505.1750 to 9505.2150 shall prevent a provider or recipient, upon receipt of a notice of intended sanction, from meeting with the commissioner to informally discuss the matter in dispute, so long as an appeal has not been commenced.

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

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 appli-

cants 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 screening 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 the effective date of parts 9505.2395 to 9505.2500, 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 public 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 discharge 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 following the effective date of parts 9505.2390 to 9505.2500, 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 statewide 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 Vocational Technical Education;

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 9505.1750 to 9505.1880;

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*

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 following the effective date of parts 9505.2390 to 9505.2500, 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 the first of July following the effective date of parts 9505.2390 to 9505.2500, 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 the effective date of parts 9505.2390 to 9505.2500 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 9505.1750 to 9505.2150.

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*

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 9505.1750 to 9505.2150, 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 9500.1070, subparts 1, 4, 6, 12 to 15, and 23; 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 subd 7 para (b)*

History: *10 SR 842; 13 SR 1688*

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-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 prior authorization in an emergency if the provider submits the request for authorization no later than five working days after providing the initial service and the provider documents the emergency.

Subp. 3. **Retroactive eligibility.** When the health service was provided on or after the date on which the recipient's eligibility began, but before the date the case was opened, a health service requiring prior authorization shall be authorized retroactively if the health service meets the criteria in part 9505.5030, and if an authorization request is submitted to the department within 20 working days of the date the case was opened.

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 20 working days of the date of the notice.

Statutory Authority: *MS s 256.991; 256D.03 subd 7 para (b)*

History: *10 SR 842; 13 SR 1688*

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 9505.1750 to 9505.2150 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 9505.1750 to 9505.2150, 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*