Department of Human Services

Adopted Permanent Rules Relating to Rehabilitation and Therapeutic Services

Rules as Adopted

9505.0290 HOME HEALTH AGENCY SERVICES.

[For text of subps 1 and 2, see M.R.]

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

[For text of items A to C, see M.R.]

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

[For text of subps 4 and 5, see M.R.]

9505.0295 HOME HEALTH SERVICES.

[For text of subpart 1, see M.R.]

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

[For text of items A to E, see M.R.]

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

[For text of items G and H, see M.R.]

[For text of subps 3 to 5, see M.R.]

9505.0385 REHABILITATION AGENCY SERVICES.

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

A. "Physical impairment" means physical disabilities including those physical disabilities that result in cognitive impairments.

B. "Rehabilitation agency" means a provider that is certified by Medicare to provide restorative therapy and specialized maintenance therapy as defined in part 9505.0390,

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subpart 1, items J and K, and to provide social or vocational adjustment services under the Code of Federal Regulations, title 42, section 405.1702, paragraph h.

Subp. 2. **Covered services.** To be eligible for medical assistance payment, the services specified in items A and B that are provided by a rehabilitation agency must be ordered by a physician, must be related to the recipient's physical impairment, and must be designed to improve or maintain the functional status of a recipient with a physical impairment:

A. physician services under part 9505.0345; and

B. rehabilitative and therapeutic services as in part 9505.0390.

Subp. 3. **Eligibility as rehabilitation agency service; required site of service.** To be eligible for medical assistance payment, a rehabilitation agency service must be provided at a site that has been surveyed by the Minnesota Department of Health and certified according to Medicare standards; or at a site that meets the standards of the State Fire Marshal as documented in the provider's records; or at the recipient's residence. <u>If the federal government denies reimbursement for services at non-Medicare certified sites, because the sites are not Medicare certified, then the eligibility for rehabilitation agency services shall be restricted to sites which meet the Medicare certification standards.</u>

Subp. 4. **Social and vocational adjustment service provided by rehabilitation agency.** A social or vocational adjustment service provided by a rehabilitation agency must meet the requirements of Code of Federal Regulations, title 42, section 405.1702, must be provided as an unreimbursed adjunct to the covered services specified in subparts 2 and 3, and is not eligible for payment on a fee for service basis.

9505.0386 COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES.

Subpart 1. **Definition.** For purposes of this part and part 9505.0410, "comprehensive outpatient rehabilitation facility" means a nonresidential facility that is established and operated

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exclusively to provide diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons, at a single fixed location, by or under the direction of a physician and that meets the conditions of participation specified in Code of Federal Regulations, title 42, section 485, subpart B.

Subp. 2. **Eligibility for payment.** To be eligible for medical assistance payment as a provider of rehabilitative and therapeutic services, a comprehensive outpatient rehabilitation facility must meet the requirements of parts 9505.0385 and 9505.0390. Additionally, mental health services provided by the comprehensive outpatient rehabilitation facility according to part 9505.0323 shall be eligible for medical assistance payment.

9505.0390 REHABILITATIVE AND THERAPEUTIC SERVICES.

Subpart 1. **Definitions.** For purposes of parts 9505.0390 to 9505.0392 and 9505.0410 to 9505.0412, the following terms have the meanings given them in this part.

A. "Audiologist" means a person who has a current certificate of clinical competence in audiology from the American Speech-Language-Hearing Association and, when it is applicable, who holds the specific state licensure and registration requirements for the services the person provides.

B. "Direction" means, notwithstanding any other definition of direction in parts 9505.0170 to 9505.0475, the actions of a physical or occupational therapist who instructs the physical ~~therapy~~ therapist assistant or the occupational therapy assistant in specific duties to be performed, monitors the provision of services as the therapy assistants provide the service, is on the premises not less than every sixth treatment session of each recipient when treatment is provided by a physical ~~therapy~~ therapist assistant or occupational therapy assistant, and meets the other supervisory requirements of parts 5601.1500 and 5601.1600.

C. "Functional status" means the ability of the person to carry out the tasks associated with daily living.

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D. "Occupational therapist" means a person who is currently registered by the American Occupational Therapy Association as an occupational therapist.

E. "Occupational therapy assistant" means a person who has an associate degree in occupational therapy and is currently certified by the American Occupational Therapy Certification Board as an occupational therapy assistant.

F. "Physical therapist" means a person who is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent and, when it is applicable, licensed by the state.

G. "Physical ~~therapy~~ therapist assistant" means a person who is qualified as specified in part 5601.0100, subpart 3.

H. "Rehabilitative and therapeutic services" means restorative therapy, specialized maintenance therapy, and rehabilitative nursing services.

I. "Rehabilitative nursing services" means rehabilitative nursing care as specified in part 4655.5900, subparts 2 and 3.

J. "Restorative therapy" means a health service that is specified in the recipient's plan of care by a physician and that is designed to restore the recipient's functional status to a level consistent with the recipient's physical or mental limitations.

K. "Specialized maintenance therapy" means a health service that is specified in the recipient's plan of care by a physician, that is necessary for maintaining a recipient's functional status at a level consistent with the recipient's physical or mental limitations, and that ~~includes~~ may include treatments ~~adjunctive~~ in addition to rehabilitative nursing services.

L. "Speech-language pathologist" means a person who has a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing

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Association and, when it is applicable, meets the specific state licensure and registration requirements for the services the person provides.

Subp. 2. **Covered service; occupational therapy and physical therapy.** To be eligible for medical assistance payment as a rehabilitative and therapeutic service, occupational therapy and physical therapy must be:

A. prescribed by a physician;

B. provided by a physical or occupational therapist or by a physical ~~therapy~~ therapist assistant or occupational therapy assistant who, as appropriate, is under the direction of a physical or occupational therapist;

C. provided to a recipient whose functional status is expected by the physician to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period; and

D. specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's attending physician at least once every 60 days unless the service is a Medicare covered service and is to a recipient who also is eligible for Medicare. If the service is to a recipient who also is eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare.

Subp. 3. **Covered service; speech-language service.** To be eligible for medical assistance payment as a rehabilitative and therapeutic service, a speech-language service must be:

A. provided upon written referral by a physician or in the case of a resident of a long-term care facility, on the written order of a physician as specified in Code of Federal Regulations, title 42, section 483.45;

B. provided by a speech-language pathologist. A person completing the clinical fellowship year required for certification as a speech-language pathologist may provide

speech-language services under the supervision of a speech-language pathologist but shall not be eligible to be enrolled as a provider under part 9505.0195;

C. provided to a recipient whose functional status is expected by the physician to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period; and

D. specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's attending physician at least once every 60 days unless the service is a Medicare covered service and is to a recipient who also is eligible for Medicare. If the service is to a recipient who also is eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare.

Subp. 4. **Covered service; audiology.** To be eligible for medical assistance payment as a rehabilitative and therapeutic service, an audiology service must be:

A. provided upon written referral by a physician;

B. provided by an audiologist. A person completing the clinical fellowship year required for certification as an audiologist may provide audiological services under the supervision of an audiologist but shall not be enrolled as a provider under part 9505.0195;

C. provided to a recipient whose functional status is expected by the physician to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period; and

D. specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's attending physician at least once every 60 days unless the service is a Medicare covered service and is to a recipient who also is eligible for Medicare. If the service is to a recipient who also is eligible for Medicare and the service is a Medicare

covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare.

Subp. 5. **Covered service; specialized maintenance therapy.** To be eligible for medical assistance payment, specialized maintenance therapy must be:

A. provided by a physical therapist, physical therapy assistant, occupational therapist, or occupational therapy assistant;

B. specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's physician at least once every 60 days unless the service is a Medicare covered service and is to a recipient who also is eligible for Medicare. If the service is to a recipient who also is eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare; and

C. provided to a recipient who cannot be treated only through rehabilitative nursing services because of a condition in subitems (1) to (5):

(1) spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care;

(2) a chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance, movement patterns, activities of daily living, or positioning necessary for completion of the recipient's activities of daily living;

(3) an orthopedic condition that may lead to physiological deterioration and require therapy intervention by an occupational therapist or a physical therapist to maintain strength, joint mobility, and cardiovascular function;

(4) chronic pain that interferes with functional

status and is expected by the physician to respond to therapy; or

(5) skin breakdown that requires a therapy procedure other than a rehabilitative nursing service.

Subp. 6. **Payment for rehabilitative nursing service in long-term care facility.** Medical assistance payment for a rehabilitative nursing service in a long-term care facility is subject to the conditions in parts 9549.0010 to 9549.0080 and 9553.0010 to 9553.0080.

Subp. 7. **Payment limitation; therapy assistants and aides.** To be eligible for medical assistance payment on a fee for service basis, health services provided by therapy assistants must be provided under the direction of a physical or occupational therapist. Services of a therapy aide in a long-term care facility are not separately reimbursable on a fee for service basis ~~and shall be included within the per diem payment under parts 9549.0010 to 9549.0080 or 9553.0010 to 9553.0080~~. Services of a therapy aide in a setting other than a long-term care facility are not reimbursable.

Subp. 8. **Excluded restorative and specialized maintenance therapy services.** Restorative and specialized maintenance therapy services in items A to K are not eligible for medical assistance payment:

A. physical or occupational therapy that is provided without a ~~written order from~~ prescription of a physician;

B. speech-language or audiology service that is provided without a written referral from a physician;

C. services provided by a long-term care facility that are included in the costs covered by the per diem payment under parts 9549.0010 to 9549.0080 and 9553.0010 to 9553.0080 including:

(1) services for contractures that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility;

(2) ambulation of a recipient who has an

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established functional gait pattern;

(3) services for conditions of chronic ~~degenerative joint~~ pain that does not interfere with the recipient's functional status and that can be managed by routine nursing measures;

(4) services for ~~maintenance of~~ activities of daily living when performed by the therapist, therapist assistant, or therapy aide; and

(5) bowel and bladder retraining programs;

D. arts and crafts activities for the purpose of recreation;

E. service that is not medically necessary;

F. service that is not documented in the recipient's health care record;

G. service ~~provided without the physician review~~ specified in a plan of care that is not reviewed, and revised as medically necessary, by the recipient's attending physician as required in subparts 2 to 5;

H. service that is not ~~related to the recipient's functional disability~~ designed to improve or maintain the functional status of a recipient with a physical impairment;

I. service that is not part of the recipient's plan of care;

J. service by more than one provider of the same type of rehabilitative and therapeutic services, for the same diagnosis unless the service is provided by a school district as specified in the recipient's individualized education plan under Minnesota Statutes, section 256B.0625, subdivision 26; and

K. service that is provided by a rehabilitation agency as defined in part 9505.0385, subpart 1, item B, and that takes place in a sheltered workshop, ~~service~~ in a developmental achievement center as defined in part 9525.1210, subpart 8, or service at a residential or group home ~~that is affiliated with a~~ which is an affiliate of the rehabilitation agency ~~as defined in part 9505.0385, subpart 1, item~~ B.

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9505.0391 THERAPISTS ELIGIBLE TO ENROLL AS PROVIDERS.

A physical therapist, an occupational therapist, an audiologist, or a speech-language pathologist is eligible to enroll as a provider if the therapist complies with the requirements of part 9505.0195 and maintains an office at the therapist's or pathologist's own expense. Additionally, a physical therapist or occupational therapist must be certified by Medicare. However, a service provided by an independently enrolled therapist or pathologist is not eligible for medical assistance payment under the therapist's or pathologist's provider number on a fee for service basis if the service was provided:

A. while the therapist or pathologist functioned as an employee of another provider; or

B. by another therapist or pathologist employed by the independently enrolled therapist unless the employee is a speech-language pathologist or an audiologist completing a clinical fellowship year.

9505.0392 COMPLIANCE WITH MEDICARE REQUIREMENTS.

Notwithstanding requirements of parts 9505.0385, 9505.0386, 9505.0390, and 9505.0391, a rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements shall not be eligible for medical assistance reimbursement.

9505.0410 LONG-TERM CARE FACILITIES; REHABILITATIVE AND THERAPEUTIC SERVICES TO RESIDENTS.

Subpart 1. **Eligible providers.** The providers in items A to F are eligible for medical assistance payment on a fee for service basis for restorative therapy and specialized maintenance therapy that is provided according to part 9505.0390 and that is provided at the site of a long-term care facility to a recipient residing in the long-term care facility:

A. a long-term care facility as defined in part 9505.0175, subpart 23;

B. a rehabilitation agency as defined in part

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9505.0385;

C. a comprehensive outpatient rehabilitation facility as defined in part 9505.0386;

D. a physical therapist as defined in part 9505.0390;

E. an occupational therapist as defined in part 9505.0390; and

F. a speech-language pathologist or audiologist as defined in part 9505.0390, subpart 1, item E.

Subp. 2. **Payment limitation.** To be eligible for medical assistance payment, rehabilitative and therapeutic services provided to recipients residing in a long-term care facility must comply with the requirements of parts 9505.0170 to 9505.0475.

Subp. 3. **Payment for restorative therapy and specialized maintenance therapy.** Medical assistance payment for restorative therapy and specialized maintenance therapy may be made ~~on a fee for service basis or as an allowable operating cost in establishing the facility per diem payment~~ according to part 9505.0445, item O, or as provided in parts 9549.0010 to 9549.0080 or 9553.0010 to 9553.0080, or as specified in the contract between the department and a prepaid health plan according to part 9505.0285.

Subp. 4. **Payment for rehabilitative nursing services.** Medical assistance payment for rehabilitative nursing services ~~may~~ shall be ~~made only as an allowable operating cost in establishing the facility per diem payment~~ as provided in parts 9549.0010 to 9549.0080 or 9553.0010 to 9553.0080, as applicable. However, payment for a rehabilitative nursing service shall not be made on a fee for service basis.

Subp. 5. **Reporting of fees for service by long-term care facility.** A long-term care facility that receives medical assistance payment on a fee for service basis for the provision of restorative and specialized maintenance therapy to a resident shall report the therapy income in accordance with parts 9549.0010 to 9549.0080 or 9553.0010 to 9553.0080, as applicable. This subpart applies to medical assistance payments

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made to the long-term care facility for therapy services provided by an employee or by a related organization. For purposes of this subpart, "related organization" has the meaning given it in Minnesota Statutes, section 256B.433, subdivision 3, paragraph (b).

Subp. 6. **Prohibited practices.** If medical assistance payment is made to a provider other than a long-term care facility for restorative therapy and specialized maintenance therapy, the long-term care facility in which the recipient resides must not request or receive payment from the provider in excess of the limit on charges specified in Minnesota Statutes, section 256B.433, subdivision 3, paragraph (c).

9505.0411 LONG-TERM CARE FACILITIES; REHABILITATIVE AND THERAPEUTIC SERVICES TO NONRESIDENTS.

Rehabilitative and therapeutic services provided by and at the site of a long-term care facility to a recipient who is not a resident of a long-term care facility are eligible for medical assistance payment if the facility is certified by Medicare as an outpatient therapy provider, under Code of Federal Regulations, title 42, part 405, subpart Q, if the service is a covered service, and if the requirements of parts 9505.0390 to 9505.0412 are met.

9505.0412 REQUIRED DOCUMENTATION OF REHABILITATIVE AND THERAPEUTIC SERVICES.

A rehabilitative or therapeutic service provided under parts 9505.0385, 9505.0386, 9505.0390, 9505.0391, 9505.0395, 9505.0396, 9505.0410, and 9505.0411 must be documented as specified in items A to D.

A. The service must be specified in the recipient's plan of care that is reviewed and revised as medically necessary by the recipient's physician at least once every 60 days. However, if the service is to a recipient who is also eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by a physician or by

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the physician delegate as required by Medicare.

B. The recipient's plan of care must state:

(1) the recipient's medical diagnosis and any contraindications to treatment;

(2) a description of the recipient's functional status;

(3) the objectives of the rehabilitative and therapeutic service; and

(4) a description of the recipient's progress toward the objectives in subitem (3).

C. The recipient's plan of care must be signed by the recipient's physician.

D. The record of the recipient's service must show:

(1) the date, type, length, and scope of each rehabilitative and therapeutic service provided to the recipient;

(2) the name or names and titles of the persons providing each rehabilitative and therapeutic service;

(3) the name or names and titles of the persons supervising or directing the provision of each rehabilitative and therapeutic service; and

(4) a statement, every 30 days, by the therapist providing or supervising the services, other than an initial evaluation, that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the recipient in accordance with Minnesota Statutes, section 256B.433, subdivision 2.

REPEALER. Minnesota Rules, part 9500.1070, subparts 12 to 15, are repealed effective July 1, 1991.

EFFECTIVE DATE. Minnesota Rules, parts 9505.0290, subpart 3; 9505.0385; 9505.0386; 9505.0390; 9505.0391; 9505.0392; 9505.0410; 9505.0411; and 9505.0412 are effective July 1, 1991.

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