Department of Human Services

Adopted Permanent Rules Relating to Prior Authorization under Medical Assistance and General Assistance Medical Care

Rules as Adopted

9505.5010 PRIOR AUTHORIZATION REQUIREMENT.

Subpart 1. **Provider requirements.** Except as provided in part 9505.5015, a provider shall obtain prior authorization as a condition of reimbursement under the medical assistance and general assistance medical care programs for health services designated under parts 9505.0170 to 9505.0475 and 9505.5025; and Minnesota Statutes, section 256B.0625, subdivision 25. Prior authorization shall assure the provider reimbursement for the approved health service only if the service is given during a time the person is a recipient and the provider meets all requirements of the medical assistance or general assistance medical care programs.

[For text of subps 2 to 4, see M.R.]

9505.5015 AFTER THE FACT AUTHORIZATION.

Subpart 1. **Exceptions.** As provided in subparts 2 to 4, medical assistance or general assistance medical care programs reimbursement shall be given for a health service for which the required authorization was requested after the health service was delivered to the recipient. The provider of the health service shall submit the request on form DHS-1856 or DHS-1855 as required in part 9505.5010, subpart 3, and shall submit materials, reports, progress notes, admission histories, or other information that substantiates that the service was necessary to treat the recipient.

Subp. 2. **Emergencies.** A health service requiring prior authorization shall retroactively receive authorization in an emergency if the provider submits the request for authorization after providing the initial service and the provider documents the emergency. Billing for emergency services must comply with

part 9505.0450.

Subp. 3. **Retroactive eligibility.** When the health service was provided on or after the date on which the recipient's eligibility began, but before the date the case was opened, a health service requiring prior authorization shall be authorized retroactively if the health service meets the criteria in part 9505.5030, and if an authorization request is submitted to the department within 180 days of the date the case was opened.

Subp. 4. **Third party liability.** A provider of a health service originally billed to Medicare or a third-party payer as defined in part 9505.0015, subpart 46, for which Medicare or the third-party payer denied payment or made a partial payment may retroactively submit a request for authorization if the provider wants to receive payment of the difference between the medical assistance or general assistance medical care payment rate for the service and the payment by the third-party payer. The service is eligible for medical assistance or general assistance medical care reimbursement if it meets the criteria in part 9505.5030 and if the authorization request is submitted to the department along with a copy of the notice explaining the denial or partial payment within 180 days of the date of the notice.

Subp. 5. **Authorization of dental prostheses.** A dental services provider who wants to obtain after the fact authorization of a removable dental prosthesis for which authorization is required under part 9505.0270, subpart 4, must submit the request on form DHS-1856 before submitting an invoice for the removable prosthesis. To obtain after the fact authorization, the removable prosthesis must meet a criterion specified in part 9505.0270, subpart 4, items A to C.

Subp. 6. **Authorization of medical supplies or equipment for recipient being discharged from hospital or long-term care facility.** Medical supplies or equipment requiring prior authorization under part 9505.0310, subpart 3, or Minnesota Statutes, section 256B.0625, subdivision 25, shall receive after the fact authorization in the case of a recipient being discharged from a hospital or long-term care facility if:

A. the provider submits a request for authorization after providing the initial service;

B. the provider documents the date of the recipient's discharge from the long-term care facility or hospital;

C. the recipient's discharge plan specifies the medical supplies or equipment as medically necessary and appropriate for the recipient's home care; and

D. the medical supplies and equipment are eligible for medical assistance payment under part 9505.0310.