

87, March 16

P182

STATE OF MINNESOTA

# STATE REGISTER

DEPARTMENT OF ADMINISTRATION—DOCUMENTS DIVISION

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Monday 16 March 1987

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# STATE REGISTER

## Judicial Notice Shall Be Taken of Material Published in the *State Register*

The *State Register* is the official publication of the State of Minnesota, containing executive orders of the governor, proposed and adopted rules of state agencies, official notices to the public, state and non-state public contracts, grants, supreme court and tax court decisions, and a monthly calendar of cases to be heard by the state supreme court.

### Volume 11 Printing Schedule and Submission Deadlines

Vol. 11 Issue Number	*Submission deadline for Executive Orders, Adopted Rules and **Proposed Rules	*Submission deadline for State Contract Notices and other **Official Notices	Issue Date
37	Monday 2 March	Monday 9 March	Monday 16 March
38	Monday 9 March	Monday 16 March	Monday 23 March
39	Monday 16 March	Monday 23 March	Monday 30 March
40	Monday 23 March	Monday 30 March	Monday 6 April

\*Deadline extensions may be possible at the editor's discretion; however, none will be made beyond the second Wednesday (12 calendar days) preceding the issue date for rules, proposed rules and executive orders, or beyond the Wednesday (5 calendar days) preceding the issue date for official notices. Requests for deadline extensions should be made only in valid emergency situations.

\*\*Notices of public hearings on proposed rules and notices of intent to adopt rules without a public hearing are published in the Proposed Rules section and must be submitted two weeks prior to the issue date.

Instructions for submission of documents may be obtained from the State Register editorial offices, 504 Rice Street, St. Paul, Minnesota 55103, (612) 296-4273.

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Publications containing news and information from the Minnesota Senate and House of Representatives are available free to concerned citizens and the news media. To be placed on the mailing list, write or call the offices listed below:

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Contact: House Information Office  
Room 175 State Office Building, St. Paul, MN 55155  
(612) 296-2146

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How to Follow State Agency Rulemaking Action in the State Register

State agencies must publish notice of their rulemaking action in the State Register. If an agency seeks outside opinion before promulgating new rules or rule amendments, it must publish a NOTICE OF INTENT TO SOLICIT OUTSIDE OPINION also.

The PROPOSED RULES section contains:

- Proposed new rules (including notice of hearing and/or notice of intent to adopt rules without a hearing).
Proposed amendments to rules already in existence in the Minnesota Rules.
Proposed emergency rules.
Withdrawal of proposed rules (option; not required).

The ADOPTED RULES section contains:

- Notice of adoption of new rules and rule amendments adopted without change from the previously published proposed rules. (Unchanged adopted rules are not republished in full in the State Register unless requested by an agency.)
Adopted amendments to new rules or rule amendments (adopted changes from the previously published proposed rules).
Notice of adoption of emergency rules.
Adopted amendments to emergency rules (changes made since the proposed version was published).
Extensions of emergency rules beyond their original effective date.

The OFFICIAL NOTICES section includes (but is not limited to):

- Notice of intent to solicit outside opinion before promulgating rules.
Additional hearings on proposed rules not listed in original proposed rules calendar.

ALL ADOPTED RULES and ADOPTED AMENDMENTS TO EXISTING RULES published in the State Register and filed with the Secretary of State before April 8, 1985 are published in the Minnesota Rules 1985. ADOPTED RULES and ADOPTED AMENDMENTS TO EXISTING RULES filed after April 8, 1985 are included in a supplement published in Spring, 1986. Proposed and adopted EMERGENCY (formerly called TEMPORARY) RULES appear in the State Register but are generally not published in the Minnesota Rules due to the short-term nature of their legal effectiveness. Those that are long-term may be published.

The State Register publishes partial and cumulative listings of rule in the MINNESOTA RULES AMENDMENTS AND ADDITIONS list on the following schedule:

Table with 2 columns: Issue range and Issue number. Includes: Issues 1-13, inclusive; Issues 14-25, inclusive; Issue 26, cumulative for 1-26; Issues 27-38, inclusive; Issue 39, cumulative for 1-39; Issues 40-51, inclusive; Issue 52, cumulative for 1-52.

MINNESOTA RULES
Amendments and Additions

NOTE: This listing includes all proposed and adopted rules printed in this issue except emergency rules and errata for this issue. Please see those sections for the appropriate rule numbers.

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# PROPOSED RULES

Pursuant to Minn. Stat. of 1984, §§ 14.22, an agency may propose to adopt, amend, suspend or repeal rules without first holding a public hearing, as long as the agency determines that the rules will be noncontroversial in nature. The agency must first publish a notice of intent to adopt rules without a public hearing, together with the proposed rules, in the *State Register*. The notice must advise the public:

1. that they have 30 days in which to submit comment on the proposed rules;
2. that no public hearing will be held unless 25 or more persons make a written request for a hearing within the 30-day comment period;
3. of the manner in which persons shall request a hearing on the proposed rules; and
4. that the rule may be modified if the modifications are supported by the data and views submitted.

If, during the 30-day comment period, 25 or more persons submit to the agency a written request for a hearing of the proposed rules, the agency must proceed under the provisions of §§ 14.14-14.20, which state that if an agency decides to hold a public hearing, it must publish a notice of intent in the *State Register*.

Pursuant to Minn. Stat. §§ 14.29 and 14.30, agencies may propose emergency rules under certain circumstances. Proposed emergency rules are published in the *State Register* and, for at least 25 days thereafter, interested persons may submit data and views in writing to the proposing agency.

## Capitol Area Architectural and Planning Board

### Proposed Rules Governing Capitol Area Zoning and Design

#### Note of Proposed Adoption of a Rule without a Public Hearing

Notice is hereby given that the Capitol Area Architectural and Planning Board (hereinafter the CAAPB) proposes to adopt the above-entitled rule without a public hearing following the procedures set forth in Minnesota Statutes, section 14.22 to 14.28. The specific statutory authority to adopt the rule is Minnesota Statutes sections 15.50, Subd. 2(a).

Persons interested in this rule shall have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule and comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the CAAPB will proceed pursuant to Minnesota Statutes, sections 14.131 to 14.20.

Persons who wish to submit comments or a written request for a public hearing must submit such comments or requests to:

Gary Grefenberg  
Capitol Area Architectural and Planning Board  
B-46 State Capitol  
St. Paul, MN 55155  
(612) 296-7138

The proposed rule may be modified if the modifications are supported by data and views and do not result in a substantial change in the proposed rule as noticed.

A copy of the proposed rule was published at *State Register*, Volume 10, Number 49, page 2367, June 2, 1986 (10 SR 2367), and an errata was published at *State Register*, Volume 10, Number 53, page 2642, June 30, 1986 (10 SR 2642). A copy of the proposed rule is available from CAAPB upon request.

A statement of Need and Reasonableness that describes the need for and reasonableness of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from CAAPB upon request.

If no hearing is required, upon adoption of the rule, the rule and the required supporting documents will be delivered to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Gary Grefenberg.

Gary Grefenberg, Executive Secretary  
Capitol Area Architectural and Planning Board

## **Housing Finance Agency**

### **Proposed Permanent Rule Relating to Income Limits for Tax Reform Transition Demonstration Program**

#### **Notice of Intent to Adopt Rules without a Public Hearing**

Notice is hereby given that the Minnesota Housing Finance Agency ("agency") proposes to adopt the above-entitled rules without a public hearing. The agency has determined that the proposed adoption of these rules will be noncontroversial in nature and has elected to follow the procedures set forth in Minn. Stat. Sec. 14.21 to 14.28.

Persons interested in these rules shall have 30 days to submit comments in support of or in opposition to the proposed rules within the 30-day comment period. Such comments are encouraged, and should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed. The proposed rule may be modified as the result of comments received if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change in the proposed language. Unless twenty-five or more persons submit written requests for a public hearing on the proposed rule within the 30-day comment period, a public hearing will not be held. In the event a public hearing is required, the agency will proceed according to the provisions of Minn. Stat. Sec. 14.14 *et. seq.* Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed.

Persons who wish to submit comments or a written request for a public hearing should submit such comments or requests to:

Kathleen J. Johnson  
Legal Division  
Minnesota Housing Finance Agency  
Suite 300  
400 Sibley Street  
St. Paul, Minnesota 55101  
Telephone: (612) 296-9794

Authority for the adoption of these rules is contained in Minn. Stat. Sec. 462A.06, Subd. 4 and 11. Additionally, a Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rules, and that identifies the data and information relied upon to support the proposed rules has been prepared and is available from Kathleen J. Johnson upon request.

Upon adoption of the final rules without a public hearing, the proposed rules, this notice, the Statement of Need and Reasonableness, all written comments received, and the final rules as adopted will be delivered to a designee of the Attorney General for review as to form and legality, including the issue of substantial change, and to determine whether the agency has the authority to adopt the rules and whether the record demonstrates a rational basis for the need for and reasonableness of the proposed rules. Persons who wish to receive notice of the date of submission of these rules to the Attorney General for review, or who wish to receive a free copy of the final rules as adopted, should make such requests to Kathleen J. Johnson.

A copy of the proposed rule is attached to this notice. Additional copies may be obtained by contacting Kathleen J. Johnson.

Please be advised that Minn. Stat. Ch. 10A.03 requires each lobbyist to register with the State Ethical Practices Board within five (5) days after he or she commences lobbying. A lobbyist is defined in Minn. Stat. Sec. 10A.01, Subd. 11 as any individual:

(a) Engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than \$250.00, not including his own travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials; or

(b) Who spends more than \$250.00, not including his own traveling expenses and membership dues, in any year for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

**KEY: PROPOSED RULES SECTION** — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

# PROPOSED RULES

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, St. Paul, Minnesota 55155 (612) 296-5615.

Dated: March 13, 1987

James J. Solem  
Executive Director

## Rules as Proposed (all new material)

### INCOME LIMITS FOR TAX REFORM TRANSITION DEMONSTRATION PROGRAM

#### 4900.0381 INCOME LIMITS FOR TAX REFORM TRANSITION DEMONSTRATION PROGRAM.

For the purpose of tax reform transition demonstration program loans, "persons and families of low and moderate income" means those persons and families whose annual projected gross income does not exceed the amounts set forth in items A and B or a lower amount as required to assure that the interest on obligations of the Minnesota Housing Finance Agency will be exempt from federal income taxation. "Gross annual income" means the income from all sources, and before taxes or withholding, of all the residents, age 18 and over, of a housing unit.

A. The following limits constitute maximum gross income for loans for new construction:

(1) in the counties of Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Washington, and Wright:

Mortgage Interest Rate	Maximum Gross Income
0 - 9.00	\$34,000
9.01 - 9.50	\$35,000
9.51 - 10.00	\$36,000
10.01 - 10.50	\$37,000
10.51 - 11.00	\$37,900
11.01 and Over	\$37,900

(2) in the counties of Benton, Blue Earth, Clay, Nicollet, Olmsted, St. Louis, Sherburne, and Stearns:

Mortgage Interest Rate	Maximum Gross Income
0 - 9.00	\$27,000
9.01 - 9.50	\$28,000
9.51 - 10.00	\$29,000
10.01 - 10.50	\$30,000
10.51 - 11.00	\$31,000
11.01 and Over	\$32,000

(3) in all other counties:

Mortgage Interest Rate	Maximum Gross Income
0 - 9.00	\$25,000
9.01 - 9.50	\$26,000
9.51 - 10.00	\$27,000
10.01 - 10.50	\$28,000
10.51 - 11.00	\$29,000
11.01 and Over	\$30,000

B. The following limits constitute maximum gross income for loans for existing construction:

(1) in the counties of Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Washington, and Wright:

Mortgage Interest Rate	Maximum Gross Income
0 - 9.00	\$30,000
9.01 - 9.50	\$31,000
9.51 - 10.00	\$32,000
10.01 - 10.50	\$33,000
10.51 - 11.00	\$34,000
11.01 and Over	\$35,000



(2) in the counties of Benton, Blue Earth, Clay, Nicollet, Olmstead, St. Louis, Sherburne, and Stearns:

Mortgage Interest Rate	Maximum Gross Income
0 - 9.00	\$22,000
9.01 - 9.50	\$23,000
9.51 - 10.00	\$24,000
10.01 - 10.50	\$25,000
10.51 - 11.00	\$26,000
11.01 and Over	\$27,000

(3) in all other counties:

Mortgage Interest Rate	Maximum Gross Income
0 - 9.00	\$20,000
9.01 - 9.50	\$21,000
9.51 - 10.00	\$22,000
10.01 - 10.50	\$23,000
10.51 - 11.00	\$24,000
11.01 and Over	\$25,000

## Department of Human Services

### Proposed Permanent Rules Relating to Medical Assistance Payment

#### Notice of Hearing

NOTICE IS HEREBY GIVEN that a public hearing on the above-entitled matter will be held in the Veterans Home Auditorium, Building 15, 5101 Minnehaha Avenue South, Minneapolis, MN 55417 on April 15 and 16, 1987 commencing at 9:00 a.m. and continuing until all interested or affected persons have an opportunity to participate. The proposed rules may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rules, you are urged to participate in the rule hearing process.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to participate. Such persons may present their views either orally at the hearing or in writing at any time prior to the close of the hearing record. All evidence presented should be pertinent to the matter at hand. Written material not submitted at the time of the hearing which is to be included in the hearing record may be mailed to Peter Erickson, Administrative Law Judge, Office of Administrative Hearings, 400 Summit Bank Building, 310 Fourth Avenue South, Minneapolis, Minnesota 55415; telephone (612) 341-7606, either before the hearing or within five working days after the public hearing ends. The Administrative Law Judge, may at the hearing, order the record be kept open for a longer period not to exceed 20 calendar days. The comments received during the comment period shall be available for review at the Office of Administrative Hearings. Following the close of the comment period the agency and all interested persons have three business days to respond in writing to any new information submitted during the comment period. During the three-day period, the agency may indicate in writing whether there are amendments suggested by other persons which the agency is willing to adopt. No additional evidence may be submitted during the three-day period. The written responses shall be added to the rulemaking record. Upon the close of the record the Administrative Law Judge will write a report as provided for in Minnesota Statutes, section 14.50. The rule hearing is governed by Minnesota Statutes, section 14.01 to 14.56 and by Minnesota Rules, parts 1400.0200 to 1400.1200. Questions about procedure may be directed to the Administrative Law Judge.

Minnesota Rules, parts 9505.0170 to 9505.0475 establish the conditions to participate as a provider of medical assistance services; the services that are eligible for medical assistance payment and the limitations on the frequency with which the same or similar services may be covered by medical assistance for an individual recipient; the recipient's right to choose a provider; professional services advisory committee; competitive bidding provisions; records to be kept by providers; billing procedures; payment limitation

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## PROPOSED RULES

on parties affiliated with a provider; payment limitations on leave days for recipients residing in long-term care facilities; procedures applicable to resident fund accounts maintained by long-term care facilities for residents; payment rates for services; recovery of payments to providers; and suspension of providers convicted of crimes related to Medicare or Medicaid. The areas of service included in this rule are chiropractic, ambulatory surgical center, abortion, clinic, community health clinic, dental, EPSDT, family planning, health care prepayment plans, home health agency, home health, inpatient hospital, laboratory and x-ray, medical supplies and equipment, medical transportation, nurse-midwife, nutritional products, outpatient, personal care, pharmacy, physician, podiatry, prenatal care, preventive health, private duty nursing, prosthetic and orthotic devices, public health clinic, rural health clinic, and vision care.

The agency's authority to adopt the proposed rules is contained in Minnesota Statutes, section 256B.04, subdivisions 4 and 12.

Adoption of these rules will not result in additional spending by local public bodies in the excess of \$100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11. A fiscal note prepared according to the requirements of Minnesota Statutes, section 3.98, subdivision 2, estimating the fiscal impact of the rule is available upon request from Eleanor Weber, Department of Human Services, Space Center, 444 Lafayette Road, St. Paul, MN 55101, (612) 297-4301.

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to Eleanor Weber, Department of Human Services, Space Center, 444 Lafayette Road, St. Paul, MN 55101 (612) 297-4301. A copy of the rule may also be viewed at any of the 87 county welfare agencies in the State of Minnesota.

Additional copies will be available at the hearing. If you have any questions on the content of the rule, contact Larry Woods, Department of Human Services, Space Center, 444 Lafayette Road, St. Paul, MN 55101, (612) 296-2846.

NOTICE: Any person may request notification of the date on which the Administrative Law Judge's report will be available, after which date the agency may not take any final action on the rules for a period of five working days. If you desire to be notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the Administrative Law Judge. Any person may request notification of the date on which the rules were adopted and filed with the secretary of state. The notice must be mailed on the same day the rules are filed. If you want to be so notified you may so indicate at the hearing or send a request in writing to the agency at any time prior to the filing of the rules with the secretary of state.

NOTICE IS HEREBY GIVEN that a Statement of Need and Reasonableness is now available for review at the agency and at the Office of Administrative Hearings. The Statement of Need and Reasonableness includes a summary of all the evidence and argument which the agency anticipates presenting at the hearing justifying both the need for and reasonableness of the proposed rules. Copies of the Statement of Need and Reasonableness may be reviewed at the agency or the Office of Administrative Hearings and copies may be obtained from the Office of Administrative Hearings at the cost of reproduction.

Minnesota Statutes, chapter 10A, requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minnesota Statutes, section 10A.01, subdivision 11, as any individual:

(a) engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than \$250, not including travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communication or urging others to communicate with public officials; or

(b) who spends more than \$250, not including traveling expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 625 North Robert Street, St. Paul, Minnesota 55101, telephone (612) 296-5148.

Sandra Gardebring, Commissioner

### Rules as Proposed (all new material)

#### CHAPTER 9505

#### DEPARTMENT OF HUMAN SERVICES

#### MEDICAL ASSISTANCE HEALTH SERVICES

##### 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.

**9505.0175 DEFINITIONS.**

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

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

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

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

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

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

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

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

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

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 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, section 256B.02, subdivision 8.

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.

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## PROPOSED RULES

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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 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 serious physical or mental disability; or to care for the mother and child through the maternity period; or to restore an achievable level of physical or mental function; 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" means a person qualified under part 9520.0760, subpart 18 to provide clinical services in the treatment of mental illness.

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 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 written approval and issuance of an authorization number by the department to a provider before the provision of a covered service as specified in part 9505.5010.

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.

#### **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.

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## PROPOSED RULES

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Subp. 3. **Surveillance and utilization review.** The surveillance and utilization review program must have a postpayment 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.

### 9505.0185 PROFESSIONAL SERVICES ADVISORY COMMITTEE.

Subpart 1. **Appointees.** The commissioner may 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.

### 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.

### 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 parts 9505.0170 to 9505.0475 and 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.

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, control, or assets 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. If the purchaser or transferee fails to notify the department within the required time, the purchaser or transferee shall be subject to monetary recovery of payments resulting from error or abuse by the seller or transferor as provided in parts 9505.1750 to 9505.2150. 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.

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## PROPOSED RULES

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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.

### 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.

### 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.

### 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.

### 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.

**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 in full for the cost of a health service paid by the recipient during the retroactive eligibility period;

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 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. 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 full 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, section 256B.02, subdivision 8;

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;

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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.

### **9505.0221 PAYMENT LIMITATION; PARTIES AFFILIATED WITH A PROVIDER.**

Equipment, supplies, or services prescribed or ordered by a physician and provided or supplied by an affiliate of the physician are not eligible for medical assistance payment.

For purposes of this part, "affiliate" means a person related to the prescribing physician as spouse, parent, child, or sibling, or a person or entity that has a financial relationship to the physician who prescribed or ordered the equipment, supply, or service.

### **9505.0225 REQUEST TO RECIPIENT TO PAY.**

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

**Subpart 1. 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 co-payment 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. 2. Payment for noncovered service.** A provider who furnishes a recipient a with 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.

### **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 titre, 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.

### **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.

#### **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.

#### **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

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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.

### 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 E 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; and
- E. dental services under part 9505.0270.

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.

### 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 soft mouth parts.
- D. "Reline" refers to resurfacing the portion of the denture base that rests on the recipient's soft mouth parts.
- E. "Removable prosthesis" means a removable structure that is prescribed by a dentist to replace a full 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 under 16 years of age unless prior authorization is obtained.
- D. One full mouth or panoramic X-ray survey every five years unless an additional survey is medically necessary and prior authorization is obtained.

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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 under 16 years of age 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. 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 is eligible for payment if 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.

(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. 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;

E. surgical services except emergencies and alveolectomies;

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

G. removal of impacted teeth.

**Subp. 6. 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. 7. Payment limitation; removable prosthesis.** The payment rate for a removable prosthesis that received prior authoriza-

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tion 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. 8. **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.

Subp. 9. **Excluded dental services.** The dental services in items A to N are not eligible for payment under the medical assistance program:

- A. additional clasps for partial prostheses;
- 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;
- M. gold restoration or inlay, including cast nonprecious and semiprecious metals; and
- N. full mouth or panoramic X-rays for a recipient under eight years of age unless prior authorization is given.

### 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 9505.1500 to 9505.1690.

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 9505.1500 to 9505.1690 and Code of Federal Regulations, title 42, sections 441.50 to 441.62.

### 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.

**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.

**9505.0290 HOME HEALTH AGENCY SERVICES.**

Subpart 1. **Definition.** For the purpose 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 purpose 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, subdivision 3.

B. Home health aide services provided under the direction of a registered nurse on the order of a physician. For the purpose 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.

**9505.0295 HOME HEALTH SERVICES.**

Subpart 1. **Definition.** For the purpose 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 G are eligible for medical assistance payment:

A. nursing services under part 9505.0290;

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- 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. medical supplies and equipment ordered in writing by a physician or doctor of podiatry; and
- G. 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 the effective date of this part 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 the effective date of this part 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-St. 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 facility 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 facility for the physically handicapped.

(2) Home health services may be provided for a recipient determined by the screening team not to be eligible for placement in a residential facility for the physically handicapped operated under parts 9570.2000 to 9570.3600, if the total payment for a month of home health services is less than the total monthly statewide average rate for the case mix classification most appropriate to the recipient.

(3) Home health services may be provided for a ventilator-dependent recipient if the screening team determines the recipient's health care needs can be provided in the recipient's residence and the cost of home health services is less than the projected monthly cost of services provided by the least expensive hospital in the recipient's local trade area that is staffed and equipped to provide the recipient's necessary care. The recipient's physician in consultation with the staff of the hospital shall determine whether the hospital is staffed and equipped to provide the recipient's necessary care. The hospital's projected monthly cost must be computed by multiplying the projected monthly charges that the hospital would bill to medical assistance for services to the recipient by the hospital's cost-to-charge ratio as determined by a medical assistance settlement made under title XIX of the Social Security Act.

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

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

- A. approval by the department is obtained before screening is done; or
- B. the screening team and provider of personal care services are parts of a governmental personnel administration system.

### 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.

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.

#### **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.

#### **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. 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

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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 9549.0070.

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 G 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 for which a claim has been denied by Medicare as not medically necessary;

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

F. dental hygiene supplies and equipment; and

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

### 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 life support transportation services, that may be medically necessary on an individual basis, but are not routinely used, and are not included in the base rate for life support transportation.

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

C. "Life support transportation" 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 life support transportation.

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 sheltered workshop 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 life support transportation 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; life support transportation.**

To be eligible for the medical assistance payment rate as a life support transportation, the transportation must comply with the conditions in items A to E.

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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 life support transportation service.

B. The provider must identify the type of service as advanced, basic, or scheduled life support transportation in the claim for payment.

C. The medical necessity of the life support transportation 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 or a police or fire department call. Except as in item E, a life support transportation service that responds to a 911 emergency call or a police or fire department call but does not transport a recipient as a result of the call is not eligible for medical assistance payment.

E. Life support transportation that responds to a medical emergency is eligible for payment for no load transportation only if the life support transportation 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 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 E.

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 resident of a long-term care facility is covered under the payment rates established under parts 9549.0010 to 9549.0080 and 9553.0010 to 9553.0080.

D. 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.

E. 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.

### 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.

### 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.

#### **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:

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- 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.

### 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.

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 four or more qualified recipients 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 the effective date of this part 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 as approved 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.

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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 except as provided in subpart 7. 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 administering 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 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 request 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.

#### **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

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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.

**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, section 256B.02, subdivision 8, 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 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;

(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 by appropriate labeling on the prescription's container. The notice to the department must be by appropriate billing codes.

H. The amount of the dispensing fee shall be set by the commissioner.

I. 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.

#### **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.

**KEY: PROPOSED RULES SECTION** — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

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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 or review 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 one per month 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.

**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.

### 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 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.

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.

#### **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.

**KEY: PROPOSED RULES SECTION** — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

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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 psycho-social 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 pre-term labor, warning signs of pre-term 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.

### 9505.0355 PREVENTIVE HEALTH SERVICES.

Subpart 1. **Definition; preventive health service.** For the purpose 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.

#### **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 life support transportation; 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 that is a provider is not available in the recipient's local trade area or 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.

#### **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.

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.

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- 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 related to the prescribing physician as spouse, parent, child, or sibling, or a person or an entity that has a financial relationship to the physician who prescribed the device or to the consultant; and
- K. replacement batteries provided on a schedule under contract.

### 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 E 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. dental services as in part 9505.0270; and
- E. early and periodic screening diagnosis and treatment as in part 9505.0275.

### 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.

### 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 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 and B.

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.

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.

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.

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L. Services or materials that are determined to be experimental or nonclinically proven by prevailing community standards or customary practice.

### 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 portion of a calendar day that exceeds 18 hours other than the day of return to the facility during which the recipient is absent from the long-term care facility. 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.

F. "Therapeutic leave" means the transfer of a recipient from a long-term care facility, with the expectation of the recipient's return to the facility, to a camp licensed by 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.

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 to C if the leave day is to be eligible for payment under medical assistance.

A. The recipient's plan of care must document the purpose of the therapeutic leave and the goals of the therapeutic leave.

B. The recipient's health care record must document the date the recipient leaves the long-term care facility and the date of return.

C. 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.

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 a full calendar month 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.

#### **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 9505.1070, 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.

#### **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. The funds in a recipient's resident fund account must be used solely for the well-being of the recipient.

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Subp. 2. **Administration of resident fund accounts.** A long-term care facility must administer a resident fund account as in items A to I.

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 a deposit or withdrawal within five working days after the deposit or withdrawal.

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.

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 to the department a recipient's donation of money to the facility.

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, 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.

### **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.

### **9505.0440 MEDICARE BILLING REQUIRED.**

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.

### **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 9549.0050 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, podiatric 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 the effective date of this rule 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-St. Paul area new series index (1967100) 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-St. 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.

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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 life support transportation 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 divided by the number of persons being transported. Payment for ancillary service to a recipient during life support transportation 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, 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.

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.

### 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 the provider's usual and customary charge during this period, the provider must reimburse the recipient.

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 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 nonprocessable 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.

#### **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.

#### **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.

#### **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 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

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## PROPOSED RULES

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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.

### 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.

### 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.

## Rules as Proposed

### 9500.1070 SERVICES COVERED BY MEDICAL ASSISTANCE.

Subpart 1. [Unchanged.]

Subp. 2. and 3. [See Repealer.]

Subp. 4. **Physician services.** In addition to complying with part 9505.0345, physician services are those services provided by or under the personal supervision of a licensed physician or osteopath within the scope of his profession as defined by state law. All physicians currently licensed to practice medicine under Minnesota law are eligible to participate in the MA program. Out-of-state physicians who are licensed in the state of service are also eligible for participation in Minnesota's MA program. The MA program shall pay for all emergency and medically necessary health care must comply with items A and B.

A. The following physician services must receive Prior authorization:

- (1) all medical, surgical, or behavioral modification services aimed specifically at weight reduction;
- (2) surgery and other procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to interfere with the individual's personal and social adjustment or employability;
- (3) removal of tattoo;



(4)~~[Repealed, 10 SR 842]~~

(5) must be obtained for individual hourly sessions with a psychiatrist licensed to practice medicine in the United States or Canada in excess of ten per calendar year.

B. [Unchanged.]

Subp. 5. [See Repealer.]

Subp. 6. **Other licensed practitioners.** The MA program shall pay for ~~medical and remedial care or services, other than physicians' services, provided by a practitioner currently licensed under Minnesota law and performed within the scope of his practice as defined by state law. Out-of-state practitioners who are licensed in the state of service are also eligible to participate in Minnesota's MA program. This category is limited to services provided by licensed chiropractors, podiatrists, vision care providers, psychologists, nurse-midwives, osteopaths not licensed to practice medicine and surgery, and by public health nurses. Limitations on the number of treatments pertain to each eligible recipient per calendar year.~~

A. **Chiropractors.** Chiropractors must be licensed and conform to the uniform minimum standards promulgated by the secretary of health, education and welfare under title XVIII of the Social Security Act, as amended. The MA program limits payment for services provided by chiropractors as follows:

(1) The request for chiropractic services must originate with the recipient, his family or caseworker and may proceed only with the recipient's full knowledge and consent.

(2) Payment is limited to manual manipulation of the spine for a diagnosis of subluxation of the spine. No other chiropractic service is covered under the MA program.

(3) Payment is limited to six treatments per month and 24 treatments per calendar year for each eligible recipient. Treatment in excess of these maxima must receive prior authorization.

(4) The MA program shall not cover Xrays nor any other diagnostic or laboratory procedure provided by a chiropractor.

B. **Podiatrists.** The MA program limits payment for podiatry services as follows:

(1) The request for podiatry services must originate with the recipient, his family, his caseworker or, where applicable, the staff of the long term care facility wherein he resides, and may proceed only with the patient's full knowledge and consent.

(2) A limit of three visits per month and 12 visits per year is placed on the following: total office and outpatient visits, total home or long term care facility visits, and hospital visits.

(3) Treatment in excess of these maxima must receive prior authorization.

(4) The following podiatry services are not covered under the MA program for long term care facility patients: ordinary foot hygiene, use of skin creams to maintain skin tone, and normal trimming of nails and other services that can reasonably and safely be performed by LTC facility personnel.

C. **Vision care.** "Optometric services" are those services provided by or under the personal supervision of a licensed optometrist within the scope of his profession as defined by state law. "Eyeglasses" are lenses (including frames when necessary) and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the patient may select, to aid or improve vision. Eligible providers include optometrists currently licensed by the Board of Optometry, ophthalmologists currently licensed by the state, opticians who are normally associated with the fabrication and/or dispensing of materials, and out-of-state providers in one of the above classifications licensed by the state of service psychological services of eligible providers.

(1) The following vision care services must receive prior authorization:

(a) Contact lenses: supplemental contact lens evaluation; contact lens check-up; spherical lens fitting (single vision); cylindrical, lenticular, aphakic, or prism ballast lenses; keratoconus lenses; cosmetic lenses (disfigurement only); fitting previous contact lens wearer; soft contact lens fitting; fitting monocular patient;

(b) Custom-fit prosthetic eye;

(c) Amblyopia therapy: "Amblyopia" includes all test procedures necessary for classification and determination of expecteds.

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## PROPOSED RULES

~~(d) Strabismus therapy: "Strabismus" includes all test procedures necessary for classification, degree of squint, and determination of expecteds.~~

~~(e) Vision therapy supplemental evaluation and report.~~

~~(f) More than one pair of eyeglasses in any single 12-month period.~~

~~(g) Photochromatic lenses: must be accompanied by a statement of medical necessity.~~

~~(h) Sunglasses: must be accompanied by statement of medical necessity.~~

~~(i) Lens coating surface or edge.~~

~~(2) The following vision care services are not covered under the MA program:~~

~~(a) services provided principally for cosmetic reasons, including contact lenses prescribed for reasons other than aphakia, keratoconus, aniseikonia, or marked acuity improvement over spectacle correction; and replacement of lenses or frames due to a recipient's personal preference for a change of style or color;~~

~~(b) technical services related to the provision of noncovered services.~~

~~D. Psychologists.~~ Eligible providers are individuals currently licensed by the Minnesota Board of Examiners of Psychologists to practice as licensed psychologists or licensed consulting psychologists in the appropriate service areas.

(1) The following psychological services must receive prior authorization: services in excess of the limitation on the number of visits (see below).

(2) The MA program limits payment for services provided by psychologists as follows:

The MA program will pay for up to ten hourly sessions with a licensed psychologist per calendar year for any eligible recipient.

The MA program will pay for up to 26 additional hourly sessions with a licensed psychologist per calendar year when all of the following conditions exist: three or more members of one family unit are all seen together at every session, the 26 hourly sessions extend over a period of time greater than six consecutive months, and at least one of the family members is under age 18.

The MA program will pay for family psychotherapy of two family members as needed for up to two hours per week for a 20-week period. When more than two family members are involved, see subitem (2).

(3) The following psychological services are not covered under the MA program: medical supplies and equipment.

~~E. Public health nurses.~~ A "public health nurse" is a registered nurse who is licensed as a professional nurse and certified by the State Board of Health as a public health nurse. The MA program limits payment for public health nurses to the following services:

~~(1) health assessment and screening;~~

~~(2) health promotion and preventive counseling;~~

~~(3) EPSDT screening if approved by the Minnesota Department of Health; and~~

~~(4) Health care services provided at the residence of the patient if the services are performed by a public health nurse and the nurse indicates in a statement submitted under oath that the services were actually provided.~~

Subp. 7. to 11. [See Repealer.]

Subp. 12. to 15. [Unchanged.]

Subp. 16. to 22. [See Repealer.]

Subp. 23. [Unchanged.]

Subp. 24. [See Repealer.]

**REPEALER.** Minnesota Rules, parts 9500.0900; 9500.0930; 9500.0960; 9500.0970; 9500.0990; 9500.1000; 9500.1060; 9500.1070, subparts 2, 3, 5, 7, 8, 9, 10, 11, 16, 17, 18, 19, 20, 21, 22, and 24; and 9505.1080 are repealed.

# ADOPTED RULES

The adoption of a rule becomes effective after the requirements of Minn. Stat. § 14.14-14.28 have been met and five working days after the rule is published in *State Register*, unless a later date is required by statutes or specified in the rule.

If an adopted rule is identical to its proposed form as previously published, a notice of adoption and a citation to its previous *State Register* publication will be printed.

If an adopted rule differs from its proposed form, language which has been deleted will be printed with strikeouts and new language will be underlined. The rule's previous *State Register* publication will be cited.

An emergency rule becomes effective five working days after the approval of the Attorney General as specified in Minn. Stat. § 14.33 and upon the approval of the Revisor of Statutes as specified in § 14.36. Notice of approval by the Attorney General will be published as soon as practicable, and the adopted emergency rule will be published in the manner provided for adopted rules under § 14.18.

## Department of Education

### Adopted Permanent Rules Relating to Community Education Directors; Licensure

The rules proposed and published at *State Register*, Volume 11, Number 15, pages 686-690, October 13, 1986 (11 S.R. 686) are adopted with the following modifications:

#### Rules as Adopted

#### COMMUNITY EDUCATION LICENSURE

##### 3510.9000 DIRECTORS OF COMMUNITY EDUCATION.

Subpart 1. **Scope.** A person who serves as a ~~district-wide~~ district director of community education shall hold a license as a director of community education.

Subp. 3. **Program requirement.** A program leading to the licensure of directors of community education must consist of a minimum of 30 quarter hours, or the equivalent, and must provide a candidate recommended for licensure with knowledge, skills, and abilities in all of the subjects listed in items A to H.

E. Program management includes:

(3) skill in recruiting and providing in-service ~~training~~ education to staff members; and

G. Philosophy and administration of community education includes:

(6) knowledge of general ~~school~~ education curriculum development;

(8) knowledge of ~~school~~ education law as it pertains to community education;

(9) knowledge of ~~school~~ education finance as it pertains to community education; and

Subp. 7. **Pre-1990 directors.** A person serving as a ~~district-wide~~ district director of community education in Minnesota between July 1, 1984, and July 1, 1990, shall, upon application and verification of one year of experience as either a part-time or full-time director of community education, be granted an entrance license as a director of community education.

## Department of Human Services

### Adopted Permanent Rules Relating to Hospital Admission Certification

The rules proposed and published at *State Register*, Volume 11, Number 23, pages 1031-1035, December 8, 1986 (11 S.R. 1031) are adopted with the following modifications:

#### Rules as Adopted

##### 9505.0520 INPATIENT ADMISSION CERTIFICATION.

Subp. 3. **Admitting physician responsibilities.** The admitting physician who seeks medical assistance or general assistance

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## ADOPTED RULES

medical care program payment for an inpatient hospital service to be provided to a recipient for a purpose other than chemical dependency treatment shall:

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

A. Obtain ~~from the admitting physician~~ the certification number from the admitting physician or, for an admission for chemical dependency treatment, from the person who conducted the assessment of the recipient for chemical dependency treatment as specified in parts 9530.6600 to 9530.6655.

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

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

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

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

### 9505.0530 INCORPORATION BY REFERENCE OF CRITERIA TO DETERMINE MEDICAL NECESSITY.

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

~~The Effective Care '84 Criteria for Residential Chemical Dependency Treatment, 1983 edition, and 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.~~

### 9505.0540 CRITERIA TO DETERMINE MEDICAL NECESSITY.

Subpart 1. Determination for admission for purpose other than chemical dependency treatment. The medical review agent shall follow the Appropriateness Evaluation Protocol ~~and Effective Care '84 Criteria for Residential Chemical Dependency Treatment~~ and Criteria for Inpatient Psychiatric Treatment of Blue Cross and Blue Shield of Minnesota in determining whether a recipient's admission is medically necessary, whether the inpatient hospital services provided to the recipient were medically necessary, whether the recipient's continued stay will be medically necessary, and whether all medically necessary inpatient hospital services were provided to the recipient.

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

## Department of Human Services

### Adopted Rules Relating to Hospital Medical Assistance and General Assistance Medical Care Reimbursement

The rules proposed and published at *State Register*, Volume 11, Number 22, pages 975-987, December 1, 1986 (11 S.R. 975) are adopted with the following modifications:

#### Rules as Adopted

##### 9500.1090 PURPOSE AND SCOPE.

Parts 9500.1090 to 9500.1155 establish a prospective reimbursement system for ~~the hospitals that participate in and are reimbursed by inpatient hospital services provided under~~ medical assistance.

##### 9500.1100 DEFINITIONS.

Subp. 32. **Medicare crossover claims.** "Medicare crossover claims" means information contained on the inpatient hospital invoices submitted to the department on forms or computer tape by a hospital to request reimbursement for medicare eligible inpatient hospital services provided to a recipient who is also eligible for medicare.

**9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF DIAGNOSTIC CATEGORIES.**

Subpart 1. **Determination of relative values.** To determine the relative values of the diagnostic categories the department shall:

E. assign each admission identified in item B to the appropriate diagnostic related group under medicare using a version of the Transfer Tape for ICD-9-CM Diagnosis Related Groups Assignment Software distributed and developed by DRG Support Group Limited, a subsidiary of Health Systems International, Incorporated, or the system in use by medicare, provided that the system of DRG assignment used must be used exclusively and uniformly throughout all ~~computations~~ determinations of rates and adjudications under parts 9500.1090 to 9500.1155;

I. for each day outlier, truncate that day outlier's reimbursable inpatient hospital cost by multiplying (the day outlier's reimbursable inpatient hospital cost by the ratio of the admission's ~~diagnostic category day outlier~~ trim point divided by the day outlier's length of stay), and then by multiplying the truncated reimbursable inpatient hospital cost by a factor 'x' determined as follows:

$$X = \frac{[\text{Length of Stay} - (0.6 \times \text{outlier days})]}{\text{Total days through the } \text{diagnostic category day outlier} \text{ trim point}}$$

When diagnostic category O under part 9500.1100, subpart 20 is used in this formula, the department shall substitute 0.6 in the formula with 0.8.

**9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION FOR A MINNESOTA HOSPITAL.**

Subpart 1. **Pass-through cost reports.** For each hospital's budget year, the hospital shall submit to the department a written report of pass-through costs, total charges billed to all payers for inpatient hospital services, total admissions for all payers, total days of inpatient hospital services for all payers, total Medical Assistance AFDC admissions, and total ~~Medical Assistance non-AFDC general assistance~~ admissions. A pass-through cost report for a hospital budget year that begins on or after July 1, 1987, must separate medical assistance admissions data into AFDC or non-AFDC admissions data. Pass-through cost reports must include actual data for the prior year and budgeted data for the current and budget years. Pass-through cost reports are due 60 days before the start of each hospital's budget year and must include the following information:

Items	Prior (Actual)	Current Year (Budget)	Budget Year (Budget)	Year
A. Pass-through costs				
(1) Depreciation		_____	_____	_____
(2) Rents and leases		_____	_____	_____
(3) Property taxes		_____	_____	_____
(4) Property insurance		_____	_____	_____
(5) Interest		_____	_____	_____
(6) Malpractice insurance		_____	_____	_____
(7) Total Pass-Through Costs (Subitems (1) to (7))		_____	_____	_____
B. Total charges billed to all payers for inpatient hospital services		_____	_____	_____
C. Total admissions for all payers		_____	_____	_____
D. Total days of inpatient hospital services for all payers		_____	_____	_____
E. Total MA AFDC admissions		_____	_____	_____
F. Total MA non-AFDC admissions		_____	_____	_____
G. Total GAMC admissions		_____	_____	_____

Pass-through costs are limited to item A, as determined by medicare. Pass-through costs do not include costs derived from capital projects requiring a certificate of need for which the required certificate of need has not been granted.

A hospital shall submit to the department a copy of the HCFA Form 2552 and the amended HCFA Form 2552 that the hospital submits to ~~medicare~~ medical assistance. An HCFA Form 2552 or an amended HCFA Form 2552 must be submitted to the department within ten working days of the day on which the form is submitted to medicare.

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## ADOPTED RULES

If medicare stops requiring HCFA Form 2552 or if the medicare/medicaid medical assistance cost report required by medicare no longer identifies capital or malpractice insurance costs in a way that is consistent with the 1985 version of HCFA Form 2552, the department may require a hospital to continue to complete and submit to the department the 1985 version of HCFA Form 2552, Worksheet D-8, part I; and Worksheet D, parts I and II.

Subp. 3. **Categorical rate per admission.** The department shall determine the categorical rate per admission as follows:

Categorical Rate Per Admission	=	[(Adjusted base year cost per admission multiplied by <u>the</u> budget year HCI and multiplied by the relative value of the appropriate diagnostic category), plus <u>the</u> budget year pass-through cost per admission]
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Subp. 4. **Pass-through cost adjustment.** After the end of each budget year, the commissioner shall redetermine the budget year pass-through cost payable by medical assistance for that budget year for a Minnesota hospital as follows:

A. For each routine service, divide the capital costs as determined on HCFA Form 2552 by the total number of days of inpatient hospital service for all payers; for example, on the 1985 version of Form 2552, on Worksheet D, Part I, divide column 1 by column 5 for each routine service type. This ~~computation~~ determination produces an allowable per-day capital cost for each routine service type.

B. Multiply the allowable per-day capital cost for each routine service type as ~~computed~~ determined in item A by the number of medical assistance days of inpatient hospital services covered during the year for the corresponding routine service type. This ~~computation~~ determination produces an allowable medical assistance share of the allowable capital costs allocated to each type of routine service.

C. ~~Compute~~ Determine the ratio of overall allowable capital costs to total charges for each type of ancillary service; for example, on the 1985 version of HCFA Form 2552, on Worksheet D, Part II, divide column 1 by column 5 for each type of ancillary service. Then multiply each ratio by the medical assistance charges billed during the year for the corresponding type of ancillary service. This ~~computation~~ determination produces an allowable medical assistance share of the allowable capital costs allocated to each type of ancillary service.

D. Determine the allowable medical assistance share of malpractice insurance costs, using the current method identified in HCFA Form 2552, Worksheet D-8; for example, from the 1985 version of HCFA Form 2552, Worksheet D-8, Part I, Column 3, line 1.

E. Sum the allowable medical assistance shares of capital costs and malpractice costs ~~computed~~ determined in items B to D to get the total medical assistance share of the hospital's allowable pass-through costs for the year.

F. Multiply the actual number of medical assistance admissions to the hospital during the year times the budgeted ~~per-admission~~ pass-through cost per-admission used in paying claims for inpatient hospital services during the year for which the adjustment is being calculated. ~~This computation produces the actual value of the pass-through cost payments made during the year.~~

G. Subtract the ~~actual value of the medical assistance pass-through cost payments during the completed year~~ (computed amount determined at item F) from the medical assistance share of allowable pass-through costs for the completed year. The remainder is the pass-through cost adjustment payable to the hospital. Negative amounts must be deducted by the department from future payments to the hospital or paid to the department by the hospital separately within 60 days of final determination of the amount owed. Positive amounts must be ~~paid~~ paid by the department to a hospital within 60 days of final determination of the amount owed. If a hospital is required by the commissioner to make separate payments of adjustment amounts owed to the department, those payments must be made within 60 days of the date of notification.

H. Amounts owed by or to the department shall earn interest at the rate charged at that time by the commissioner of the Department of Revenue for late payment of taxes, beginning for the department on the 61st day following determination of an amount owed to a hospital, and for a hospital on the ~~61st~~ 66th day following the day of the determination of the amount owed by the hospital, but no interest shall be charged to a hospital unless an explicit request for separate payment has been made by the commissioner.

### 9500.1130 REIMBURSEMENT PROCEDURES.

Subp. 4. **Adjustment to reimbursement.** Reimbursements shall be adjusted by the department for the reasons specified in subpart 5 and for inappropriate utilization as determined by the commissioner under parts 9505.1910 to 9505.2020 and as otherwise provided by law. Adjustment to a hospital's account shall be by debit.

Subp. 7. **Reimbursement for transfers.** Reimbursement for transfers shall be made as specified in items A and B.

A. Except as specified in item B, the department shall reimburse both the hospital that discharges a recipient for purposes of transfer and the hospital that admits the recipient who is transferred. Each hospital shall be reimbursed as follows:

Transfer Reimbursement =  $\frac{\{[(\text{The product of the adjusted base year cost per admission multiplied by and the budget year HCI and multiplied by the relative value of the appropriate diagnostic category, divided by the arithmetic mean length of stay of the diagnostic category}) \text{ and multiplied by the number of days of inpatient hospital services}\}, \text{ plus the budget year pass-through cost per admission}]$

In no case of a transfer may a hospital receive a reimbursement that exceeds the applicable categorical rate per admission, or out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year, unless that admission is an outlier. Reimbursements for transfers under diagnostic category 0, under part 9500.1100, subpart 20, are not limited to the categorical rate per admission, the out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals statewide that do not have admissions in the base year and such admissions are not eligible for outlier reimbursements under subpart 9.

A hospital that admits a ~~transferred~~ transfer recipient is not eligible for a transfer reimbursement under item A unless the inpatient hospital stay continues to be medically necessary.

B. A discharging hospital is not eligible for a transfer reimbursement under item A for services provided to a discharged recipient if one of the following conditions exists:

(2) except in the case of an emergency (as defined in part 9505.0500, subpart 11) admission, the discharging hospital knew or had reason to know at the time of admission that the inpatient hospital services that were medically necessary for treatment of the recipient were outside the scope of the hospital's available services and the readmission to ~~the other~~ another hospital resulted because of the recipient's need for those services.

Subp. 8. **Reimbursement for readmissions.** An admission and readmission to the same hospital for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of complications of the original diagnoses, shall be reimbursed with one applicable categorical rate per admission and as an outlier if eligible. The combined stay of the admission and readmission shall be used to determine ~~qualification~~ eligibility for outlier ~~payment~~ reimbursement. If the readmission to the same hospital is for a condition unrelated to the previous admission, including an episodic illness such as asthma or uncontrolled diabetes mellitus, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission; out-of-area hospital categorical rate per admission; categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year; transfer reimbursement; or rate per admission. An admission and subsequent readmission to a different hospital shall be reimbursed as specified under subpart 7 when the readmission is for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of foreseeable complications of the original diagnoses. If the readmission to a different hospital is due to a condition that is unrelated to the condition treated during the previous admission, including an episodic illness, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission; out-of-area hospital categorical rate per admission; categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year; transfer reimbursement; or rate per admission.

Subp. 9. **Reimbursement for outliers.** The department shall reimburse a hospital for outliers with the applicable categorical rate per admission, out-of-area categorical rate per admission, or the categorical rate per admission for a MSA or non-MSA hospital that does not have admissions in the base year, plus an amount for outliers as follows:

B. To determine reimbursements for cost outliers the department shall:

(3) subtract the cost at three standard deviations for diagnostic category W, under part 9500.1100, subpart 20 and at one standard deviation for diagnostic category O, under part 9500.1100, subpart 20 as identified in part 9500.1110, subpart 1, item ~~G~~ H from the adjusted cost from subitem (2); and

(4) multiply the ~~amount~~ difference determined in subitem (3) by 60 percent for diagnostic category W, under part 9500.1100, subpart 20 or by 80 percent for diagnostic category O, under part 9500.1100, subpart 20.

Subp. 10. **Reimbursement to an out-of-area hospital.** The department shall reimburse an out-of-area hospital ~~hospital~~ for an admission based on the lesser of billed charges for the admission or either the out-of-area hospital categorical rate per admission or the transfer reimbursement and outlier reimbursement if appropriate. The department shall determine the out-of-area categorical rate per admission as follows in items A to G:

**9500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT.**

Subpart 1. **Determination of disproportionate population adjustment.** The department shall increase the adjusted base year

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## ADOPTED RULES

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cost per admission for hospitals whose medical assistance and general assistance medical care admissions during the base year, including admissions of recipients who are also eligible for medicare and excluding admissions of participants in a prepaid health plan, exceed 15 percent of total hospital admissions according to the schedule below.

## Transportation Regulation Board

### Adopted Permanent Rules Relating to Railroad Property Right of First Refusal

#### Rules as Adopted (all new material)

#### 8910.0100 DEFINITIONS.

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

Subp. 2. **Abandonment or abandoned.** "Abandonment" or "abandoned" refers to any process by which the railroad interest seeks the approval of the Interstate Commerce Commission for approval to discontinue service on a portion of railroad track, and includes abandonment and petition for exemption from the abandonment procedures before the Interstate Commerce Commission.

Subp. 3. **Appraisal.** "Appraisal" means an estimate of the fair market value of the parcel of property offered for sale but not including those physical improvements owned by the leaseholder. An appraisal may be made by an appraiser or may be in the form of a bona fide offer from an independent third party.

Subp. 4. **Appraiser.** "Appraiser" means a person who is a qualified real estate appraiser available for state contracts as established by the state of Minnesota and may be an employee of the railroad interest if that person has met the qualifications established by the state.

Subp. 5. **Board.** "Board" means the Minnesota Transportation Regulation Board.

Subp. 6. **Bona fide offer.** "Bona fide offer" means an offer to buy underlying property without leasehold improvements from an independent third party established in a legally enforceable agreement.

Subp. 7. **Erected.** "Erected" means constructed or owned, or both.

Subp. 8. **Leasehold.** "Leasehold" means property for which there is a lease agreement between the railroad interest and the leaseholder, or as defined by mutual agreement of the leaseholder and the railroad interest.

Subp. 9. **Leaseholder.** "Leaseholder" means a person who holds a lease, license, or permit with respect to property within a right-of-way, and who has erected eligible leasehold improvements on the property with a total fair market value of \$7,500 or more.

Subp. 10. **Leasehold improvement.** "Leasehold improvement" means any structure built specifically for the pursuit of business and that has or had direct access to railroad service.

Subp. 11. **Parcel.** "Parcel" means the portion of land that is offered for sale by the railroad interest, which may be the same as, smaller than, or larger than any individual leasehold property.

Subp. 12. **Railroad interest.** "Railroad interest" includes a railroad corporation, its trustee or successor in interest, a railroad corporation that is in proceedings for bankruptcy under federal law, and a nonrailroad holding corporation that owns a controlling interest in a railroad.

Subp. 13. **Right of first refusal.** "Right of first refusal" means the right of a leaseholder to buy the parcel at a fair market price before sale of that property to any other entity.

#### 8910.0200 PURPOSE.

The purpose of this chapter is to implement Minnesota Statutes, sections 222.631 to 222.633 by establishing a procedure whereby a railroad interest must offer to leaseholders a first opportunity to purchase real property within a right-of-way that is either being abandoned or offered for sale.

#### 8910.0300 ELIGIBILITY.

Subpart 1. **Leaseholders with surface rights.** Only leaseholders with surface rights are eligible for relief under this chapter. Leaseholders with surface rights are those:

A. with property and facilities served by or formerly served by an industry side track that is owned by a railroad interest and that has lost rail service through abandonment; or

B. who have a leasehold from a railroad interest that is in bankruptcy proceedings.



Subp. 2. **Leaseholders of record.** Right of first refusal accrues to leaseholders of record with the railroad interest at the time the parcel is offered for sale by the railroad interest.

Subp. 3. **Fair market value.** The fair market value of a leasehold improvement, for purposes of eligibility under parts 9010.0100 to 9010.0400, is determined according to the latest available property tax assessment.

Subp. 4. **Limitation.** Eligibility under this part is limited to leaseholds located on rail lines that have been abandoned on or after March 22, 1986, and leaseholds that are offered for sale by a railroad interest in bankruptcy, if the offer to sell was made on or after the effective date of parts 8910.0100 to 8910.0400.

#### **8910.0400 PROCEDURE.**

Subpart 1. **Notice of intent to sell.** The railroad interest shall notify the leaseholder when it intends to sell a parcel that includes the leasehold. Notice must include the railroad interest's offering price for the parcel, a description of the parcel being offered, and the following statement: "You have a right of first refusal to purchase the subject property under Minnesota Statutes, sections 222.631 to 222.633. For more information, you may write or call the Transportation Regulation Board." The statement must also contain the address and telephone number of the board. The railroad interest is prohibited from accepting offers to purchase the parcel unless the offer is contingent on the leaseholders' rights of first refusal. The leaseholder has 15 days from receipt of notification to challenge the reasonableness of the packaging of the parcel for sale. The challenge must be served in writing on the board within 15 days. A copy of the challenge must be served on the railroad interest.

Subp. 2. **Bona fide offer.** If the railroad interest receives a bona fide offer for a parcel, it shall notify all leaseholders affected of the amount of the bona fide offer and of the parcel for which a bona fide offer exists. In addition, the notice must contain the following statement: "You have a right of first refusal to purchase the subject property under Minnesota Statutes, sections 222.631 to 222.633. For more information, you may write or call the Transportation Regulation Board." The statement must also contain the address and telephone number of the board. The leaseholder has 15 days from receipt of notification to challenge the bona fide nature of the offer or to challenge the reasonableness of the packaging of the parcel for which the offer exists, or both. The challenge must be served in writing on the board within 15 days. A copy must be served on the railroad interest. The railroad interest shall then immediately serve upon the board a copy of the bona fide offer. The contents of a bona fide offer must be treated as trade secret information under Minnesota Statutes, section 13.37, upon the filing by the data suppliers of the request accompanied by supporting affidavits.

Subp. 3. **Challenge; appraiser recommendation; board order.** If there is a challenge, the board will, within 60 days of the original notice by the board or railroad interest, issue an order approving or rejecting the railroad interest's packaging of the parcel or bona fide offer, or both. The board shall establish whether the bona fide offer is legitimate based on the following criteria: (1) offer is made by an independent third party, and (2) offerer has entered into a binding agreement with the railroad interest. The board may engage, at the expense of the leaseholder, an appraiser to evaluate the reasonableness of the packaging of the parcel. The board or its designated appraiser may interview the railroad interest officials and examine their supporting documents in preparing its review. The board may require the railroad interest to certify that the offer is an independent third party having no affiliation with the railroad interest. The appraiser shall make a recommendation to the board who will issue an order upon review of the recommendation. The criteria for establishing the reasonableness of the parcel shall include:

A. whether the leasehold can be separated out of the parcel without reducing or inhibiting the railroad interest's ability to receive fair market value for its holdings; and

B. whether a bona fide offer can still be achieved even with the removal of the leasehold from the parcel.

Subp. 4. **Leaseholder offer.** When a parcel offered for sale by the railroad interest affects more than one leaseholder, the affected leaseholders may make a joint offer or may choose to bid independently for acquisition of the entire parcel offered for sale. The railroad interest may choose which is the most acceptable offer or withdraw the parcel from sale.

Subp. 5. **Negotiation; establishing purchase price.** A leaseholder has 90 days to negotiate with the railroad and complete the acquisition of the parcel after the ruling by the board on any challenges.

In the case of an offer to sell when a bona fide offer has not been received, the leaseholder may elect within the first 30 days to secure and submit an independent appraisal to the board and the railroad interest. The railroad interest shall then have 30 days to accept the counter offer of the leaseholder, negotiate an agreement with the leaseholder, or to secure its own independent appraisal which it shall then submit to the leaseholder and the board.

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## ADOPTED RULES

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If each of the two appraisals submitted to the board is within five percent of their average, the price established by the board must be the average of the two appraisals. If the variance is greater than five percent of the average price, either the leaseholder or the railroad interest may request the board to choose a third appraiser, the costs of which must be split equally between the leaseholder and the railroad interest. The third appraiser shall report within 30 days to the board, railroad interest, and leaseholder. If an agreement cannot be reached by the 90th day of the negotiation period, a notice of dispute may be filed with the board. Within 30 days after filing of the notice of dispute, the board shall issue an order establishing the purchase price.

Subp. 6. **Agreement declined; right forfeited.** If either party declines to enter into an agreement based on the board's order, the party shall forfeit its right under this chapter; that is, the leaseholder forfeits the right of first refusal if the leaseholder withdraws. The railroad remains under an obligation to offer the right of first refusal.

Subp. 7. **Time variance.** Timelines established under this chapter may be varied by the board in accordance with the board's rules on variances.

**EFFECTIVE DATE.** Parts 8910.0100 to 8910.0400 are effective March 17, 1987, or upon compliance with Minnesota Statutes, section 14.38, subdivision 7, whichever is later.

## EXECUTIVE ORDERS

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### Executive Order 87-4 Providing for Establishment of a Code of Ethics for Governor's Appointees

I, RUDY PERPICH, GOVERNOR OF THE STATE OF MINNESOTA, by virtue of the authority vested in me by the Constitution and the applicable statutes, do hereby issue this Executive Order:

WHEREAS, effective government is premised upon public confidence in the integrity and objectivity of government officials; and

WHEREAS, a public official is entrusted with the welfare, property, security, and safety of the people he or she serves; and

WHEREAS, in return for the trust of the public, the people are entitled to know that no conflict exists between private interests and official duties in those who serve them; and

WHEREAS, there is a need to provide standards of conduct uniformly applicable to all officials of the executive branch of state government in order that government integrity remain preserved;

NOW, THEREFORE, I HEREBY ORDER THAT:

1. Gubernatorial appointees in the executive branch in the course of or in relation to their official duties shall not, directly or indirectly, receive or agree to receive any payment of expense, compensation, gift, reward, gratuity, favor, service or promise of future employment or other future benefit from any source for any activity related to the duties of the official, with the exception of:

(a) Gifts of nominal or symbolic value;

(b) Plaques or similar mementos recognizing individual services;

(c) Payment of reimbursement expenses for travel or meals, not to exceed actual expenses incurred, which are not reimbursed by the state;

(d) Honoraria or expense paid for papers, talks, demonstrations or appearances made by officials on their own time for which they are not compensated by the state.

2. That my appointees shall not use confidential information to further the official's private interest, and shall not accept outside employment or involvement in a business or activity that will require the official to disclose or use confidential information.

3. That my appointees shall not use or allow the use of state time, supplies, or state owned or

leased property and equipment for the official's private interests or any other use not in the interest of the state.

4. That my appointees shall not use or attempt to use their official position to secure benefits, privileges, exemptions, or advantages for the official or the official's immediate family or an organization with which the official is associated which are different from those available to the general public.

5. That my appointees shall not accept other employment or contractual relationships that will affect the official's independence of judgment in the exercise of official duties.

6. That my appointees shall not serve as an agent or attorney in any action or matter pending before any state agency except in the proper discharge of official duties or on the official's behalf.

7. That my appointees shall not, directly or indirectly, during hours of employment solicit or receive funds for political purposes, or use official authority or influence to compel any state employee to apply for membership in or become a member of any political organization, to pay or promise to pay any assessment, subscription, or contribution, or to take part in any political activity.

Pursuant to Minnesota Statutes, Section 4.035, this Executive Order shall be effective fifteen (15) days after publication in the *State Register* and filing with the Secretary of State and shall remain in effect until rescinded by the proper authority or it expires in accordance with Minnesota Statutes, Section 4.035, Subdivision 3.

IN TESTIMONY WHEREOF I have set my hand this twenty-fifth day of February, 1987.



GOVERNOR

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**ANNOUNCEMENTS**

**DEPARTMENT OF ADMINISTRATION: DOCUMENTS DIVISION** The 1987 Minnesota Highway Map is now available at travel information centers, tourism offices, and the Documents Division. Copies are sold at the Documents Division for 60¢ each (order Code #12-49) with discounts available for multiple orders. Call (612) 297-3000 or make your check payable to the State of Minnesota, adding 6% sales tax and \$1.50 for postage and handling and send to Minnesota Documents Division, 117 University Avenue, St. Paul, MN 55155.

**ENVIRONMENTAL QUALITY BOARD (EQB)** Opinions are sought about possible revisions to the Minnesota Environmental Review Program under which Environmental Impact Statements (EIS) and Environmental Assessment Worksheets (EAW) are prepared. The EQB invites all interested parties to submit suggestions for revisions to either the rules or statutes governing this program. Opinions and information are particularly welcomed concerning the following topics: 1) mandatory thresholds for EAWs and EISs; and 2) the process for preparing, reviewing, and responding to comments on EAWs. Materials will be received through Friday 29 May 1987 and will become part of the record. Comments should be submitted to: Gregg Downing, Environmental Review Program, 110 Capitol Square Bldg., 550 Cedar Street, St. Paul, MN 55101.

**KEY: PROPOSED RULES SECTION** — Underlining indicates additions to existing rule language. **Strike outs** indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. **Strike outs** indicate deletions from proposed rule language.

## ANNOUNCEMENTS

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**MINNESOTA HISTORICAL SOCIETY (MHS)** The public is invited to see the new MHS exhibit *Capitol in the Works: Area Under Construction*, then tour the State Capitol, with particular emphasis on new research material and the restoration work on the building. Refreshments will be served. This program is part of a series sponsored by the St. Paul Downtown Council to focus attention on things to do in downtown St. Paul. Free admission. 5-7pm at the Minnesota Historical Society, east of the State Capitol in St. Paul.

**DEPARTMENT OF JOBS & TRAINING** Twin Cities metropolitan unemployment rate was 4.7% in January, up from 4.1% in December, and compares to a jobless rate of 5.1% in January of 1986. The comparable national unemployment rate for January was 7.3%. Statewide unemployment in January was 6.4%. The number of persons employed in January was 1,246,100, down 24,000 from December and up 36,500 from January a year ago. The metropolitan area labor force in January was 1,308,100, down 16,600 from December and up 27,000 from January of last year. The number of unemployed in persons in the Twin Cities area in January was 62,000, up 7,500 from December and down 3,500 from January a year ago.

**DEPARTMENT OF NATURAL RESOURCES (DNR)** About 230 out of the original 410 packets of four-season shrubs are still available through any DNR office, Soil Conservation Service Office or county extension agent, according to Miles Wiegand, (612) 297-2973 and Tom Kroll, (612) 255-4971. The habitat created by these shrubs is especially attractive to songbirds, robins, brown-thrushers, cat birds, pheasants, cedar wax wings and mourning doves. Developed by the DNR Forestry and Wildlife Divisions and the Minnesota Nurserymen's Association, the packets cost \$125 and includes 50 seedlings of Nanking cherry, wild plum, western sandcherry, Juneberry, red osier dogwood, Russian olive, cottoneaster, ginnala maple, Manchurian crab, and red splendor crab.

## OFFICIAL NOTICES

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Pursuant to the provisions of Minnesota Statutes § 14.10, an agency, in preparing proposed rules, may seek information or opinion from sources outside the agency. Notices of intent to solicit outside opinion must be published in the *State Register* and all interested persons afforded the opportunity to submit data or views on the subject, either orally or in writing.

The *State Register* also publishes other official notices of state agencies, notices of meetings, and matters of public interest.

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### Board of Animal Health

#### Notice of Quarterly Meeting

A quarterly meeting of the Board of Animal Health has been scheduled for Friday, April 10, 1987 at the Board of Animal Health offices, St. Paul, MN at 9:30 a.m.

Information about this meeting may be obtained by calling the Board office at 612-296-5000.

Dated: 5 March 1987

Dr. Thomas J. Hagerty  
Executive Secretary

### Department of Health

#### Public Forum on Speech Language Pathologists and Audiologists and Hearing Instrument Dispensers

A public forum will be held on March 26, 1987 to receive comments on the need to regulate speech language pathologists and audiologists as well as hearing instrument dispensers in Minnesota. The Minnesota Speech and Hearing Association has requested that speech language pathologists and audiologists be licensed in Minnesota. That request is currently under review by the Department of Health.

The legislature has directed that the Minnesota Department of Health study the dispensing of hearing instruments. This study is to be done concurrently with the review of speech language pathology and audiology.

The public forum will be held from 5:00-9:00 p.m. in the Albert Chesley Room (#105) of the Minnesota Department of Health, 717 Delaware Street, S.E. Minneapolis, MN 55440. Comments regarding the need to regulate speech language pathologists and audiologists will be heard from 5:00-6:45 p.m. and for hearing instrument dispensers from 7:15-9:00 p.m.

State law requires that before the Department can make a determination regarding the need to regulate a human service occupation, it must consider (1) whether the public will be harmed if the occupation remains unregulated; (2) what kind of specialized skill or training is needed to assure competency, on the part of both new and experienced members of the occupation; (3) possible alternatives to state regulation of the occupation; and (4) the overall cost effectiveness and economic impact of regulating the occupation.

Written comments can be submitted on the day of the forum, or mailed by April 3 to the Occupational Analysis Section, Minnesota Department of Health. For more information contact Norm Hanson at (612) 623-5443.

## **Bureau of Mediation Services**

### **Notice of Solicitation of Outside Information or Opinions Regarding Proposed Rule Governing Grievances**

Notice is hereby given that the State Bureau of Mediation Services is seeking information or opinions from sources outside the agency in preparing to propose the adoption of the rule governing grievances. The adoption of the rule is authorized by Minnesota Statutes Section 179.04, subdivision 3(h), which requires the agency to adopt a grievance procedure to fulfill the purposes of section 179A.20, subdivision 4.

The State Bureau of Mediation Services requests information and opinions concerning the subject matter of the rules. Interested persons or groups may submit data or views on the subject matter of concern in writing or orally. Written statements should be addressed to: Paul W. Goldberg, Director, Minnesota Bureau of Mediation Services, 205 Aurora Avenue, St. Paul, MN 55103. Oral Statements will be received during regular business hours over the telephone at (612) 296-2525 and in person at the above address.

All statements of information and opinions shall be accepted until the close of business on Monday, March 23, 1987. Any written material received by the State Bureau of Mediation Services shall become part of the rulemaking record to be submitted to the attorney general or administrative law judge in the event that the rule is adopted.

Dated: 9 March 1987

Paul W. Goldberg, Director

## **Regional Transit Board**

### **Goals for Disadvantaged and Women Business Enterprise Participation in Urban Mass Transportation**

The Regional Transit Board announces the following goals for federal fiscal year 1987 for disadvantaged and women business enterprise (DBE and WBE) participation in Urban Mass Transportation (UMTA) assisted projects: 10% for firms owned and controlled by socially and economically disadvantaged individuals; and 2% for women-owned and controlled firms.

The goals and a description of how they were set are available for inspection during normal business hours at the Regional Transit Board offices for 30 days following the date of this notice. Comments, which are for informational purposes only, may be sent to the Regional Transit Board, Suite 270 Metro Square Building, St. Paul, MN 55101 or the U.S. Department of Transportation, 400 7th St. SW, Washington, D.C. 20590, within 45 days from the date of this notice.

## **Department of Revenue Property Tax Review Division**

### **Notice of Intent to Solicit Outside Opinion Regarding Proposed Rules Governing Valuation and Assessment of Electric, Gas Distribution, and Pipeline Companies (Utility Companies)**

Notice is hereby given that the State Department of Revenue is seeking information or opinions from sources outside the agency in preparing to promulgate revised rules governing the valuation and assessment of utility companies. The promulgation of these rules is authorized by Minnesota Statutes section 270.06 (14), which permits the agency to make rules and regulations for the administration and enforcement of the property tax law.

## OFFICIAL NOTICES

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The State Department of Revenue requests information and comments concerning the subject matter of these revised rules. Interested or affected persons or groups may submit statements of information or comment orally or in writing. Written statements should be addressed to:

Ronald Cook  
Property Tax Review Division  
Minnesota Department of Revenue  
P.O. Box 64446  
St. Paul, Minnesota 55164

Oral statements will be received during regular business hours over the telephone at (612) 642-0486 and in person at

Brown and Bigelow Building  
Garden Level, Suite 10  
450 North Syndicate Street  
St. Paul, Minnesota 55104

All statements of information and comment shall be accepted until April 15, 1987. Any written material received by the State Department of Revenue shall become part of the record in the event that the rules are promulgated.

Gerald D. Garski, Manager  
State Assessed Property Section  
Property Tax Review Division

### Department of Transportation

#### Petition of the City of South St. Paul for a Variance from State Aid Standards for Design Width

Notice is hereby given that the City Council of the City of South St. Paul has made a written request to the Commissioner of Transportation pursuant to Minnesota Rules § 8820.3300 for a variance from minimum standards for a resurfacing project on 5th Avenue from Dale Street to FAI 494 and from FAI 494 to 6th Street.

The request is for a variance from Minnesota Rules for State Aid Operations § 8820.9919 adopted pursuant to Minnesota Statutes Chapter 161 and 162, so as to permit a roadway width of 44' with parking on both sides instead of the required width of 66' with parking on both sides.

Any person may file a written objection to the variance request with the Commissioner of Transportation, Transportation Building, St. Paul, Minnesota 55155.

If a written objection is received within 20 days from the date of this notice in the *State Register*, the variance can be granted only after a contested case hearing has been held on the request.

Dated: 4 March 1987

Leonard W. Levine  
Commissioner of Transportation

### Department of Transportation

#### Petition of City of Winona for a Variance from State Aid Standards for Street Width

Notice is hereby given that the City Council of the City of Winona has made a written request to the Commissioner of Transportation pursuant to Minnesota Rules § 820.3300 for a variance from minimum standards for a reconstruction project on Second Street (MSAS 101) from Grand Street to Washington Street.

The request is for a variance from Minnesota Rules for State Aid Operations § 8820.9912 adopted pursuant to Minnesota Statutes Chapter 161 and 162, so as to permit a street width of 48' with parking on both sides instead of the required width of 72' with parking both sides.

Any person may file a written objection to the variance request with the Commissioner of Transportation, Transportation Building, St. Paul, Minnesota 55155.

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## STATE CONTRACTS & ADVERTISED BIDS

If a written objection is received within 20 days from the date of this notice in the *State Register*, the variance can be granted only after a contested hearing has been held on the request.

Dated: 5 March 1987

Leonard W. Levine  
Commissioner of Transportation

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## STATE CONTRACTS AND ADVERTISED BIDS

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6, an agency must make reasonable effort to publicize the availability of any services contract or professional and technical services contract which has an estimated cost of over \$2,000.

Department of Administration procedures require that notice of any consultant services contract or professional and technical services contract which has an estimated cost of over \$10,000 be printed in the *State Register*. These procedures also require that the following information be included in the notice: name of contact person, agency name and address, description of project and tasks, cost estimate, and final submission date of completed contract proposal. Certain quasi-state agencies are exempted from some of the provisions of this statute.

Commodities contracts with an estimated value of \$5,000 or more are listed under the Procurement Division, Department of Administration. All bids are open for 7-10 days before bidding deadline. For bid specifics, time lines, and other general information, contact the appropriate buyers whose initials appear in parentheses next to the commodity for bid, by calling (612) 296-6152.

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### Department of Administration: Procurement Division

#### Contracts and Requisitions Open for Bid

Call 296-6152 for Referral to Specific Buyers, whose initials are next to each commodity.

Commodity for Bid (and Buyer)	Bid Due Date at 2 pm	Department or Division	Delivery Point	Requisition #
Sperry upgrade (PA)	March 16	State University	Mankato	26 137 03902
Sound system & installation (PA)	March 16	State University	Bemidji	26 070 11911
Gresen pumps (DM)	March 18	Transportation	Various	Price Contract
Used pickup (DM)	March 18	Natural Resources	St. Paul	29 004 08495
Diamond core bits (DRT)	March 18	Transportation	Various	79 800 03044
Markers & Pens (AW)	March 18	Administration: Central Stores	St. Paul	Price Contract
Lumber (BV)	March 18	Natural Resources	Grand Rapids	29 007 10010
Van (DM)	March 18	Regional Treatment Center	Faribault	55 303 11791
Computers (PA)	March 18	Commerce	St. Paul	13 225 09732
Fertilizer	March 20	Natural Resources	Willow River & Akeley	29 003 04224
Boats (DRT)	March 20	Natural Resources	Grand Rapids	29 000 45683
Concrete (BV)	March 20	Transportation	Crookston	79 250 00491
Poultry (JPK)	March 20	Correctional Facility	St. Cloud	78 830 08428
Genuine repair parts for dessor crawler tractors—4 wheel (DM)	March 19	Various	Various	Price Contract
Rental of photocopy machine (JPK)	March 19	Public Safety	St. Paul	07 700 39648
Liquid petroleum gas (EFS)	March 19	Various	Various	Sch. 93A
Sound system & installation (PA)	March 20	State University	Bemidji	26 070 11911
Honeywell upgrade (PA)	March 20	Administration: Plant Mgmt.	St. Paul	02 307 52713
Modifications to van (DM)	March 23	Jobs & Training	St. Paul	21 603 50260
Terminals (PA)	March 23	Energy & Econ. Dev.	St. Paul	22 400 01471
Computer software (MJB)	March 23	Human Services	St. Paul	55 000 96058

## STATE CONTRACTS & ADVERTISED BIDS

Commodity for Bid (and Buyer)	Bid Due Date at 2 pm	Department or Division	Delivery Point	Requisition #
A complete line of safety shoes (EFS)	March 23	Various	Various	Price Contract
Steel shelving & racks (DRT)	March 23	Transportation: Central Shop	St. Paul	79 990 00062
Purchase of copier (JPK)	March 23	State University	St. Paul	26 176 02638
Mobile traffic radar—rebid (EFS)	March 24	Public Safety	St. Paul	07 500 39646
Data General equip. (PA)	March 24	State University	Bemidji	26 070 11894
Ladders, stepladders & extensions (DRT)	March 24	Various	Various	Price Contract
Bulk gasohol (EFS)	March 24	Various	Various	Sch. 92-BG Rebid
Directional beacon at Mora (BV) rebid	March 24	Transportation: Aeronautics	Same	79 000 71743
Outboard motors (DRT)	March 24	Natural Resources	Grand Rapids	29 001 10970
Trucks (DM)	March 24	Various	Various	Sch. 1130
Steel—hot rolled sheets & plates (DRT)	March 24	Correctional Facility	Stillwater	78 620 00124
Rotary core drills (DM)	March 24	Transportation	St. Paul	79 382 01204
Trailers (DM)	March 24	Transportation	Willmar	79 382 01199
Plant mix bituminous—Brainerd (BV)	March 24	Transportation	Brainerd	79 300 B
Maint. on trolley (DM)	March 24	Iron	Chisholm	43 000 07747

### Department of Administration: Printing & Mailing Services

Printing vendors for the following printing contracts must review contract specifications in printing buyers office at 117 University Avenue, Room 134-B, St. Paul, MN.

Commodity for Bid (and Buyer)	Bid Due Date at 2 pm	Department or Division	Delivery Point	Requisition #
MN Nonsmoking Initiative, 6/86- 12/86: A Report to the 1987 Legislature	March 3	Health	Minneapolis	5458 12500 10337

### Department of Administration Division of State Building Construction

#### Contracts Available for Architects, Engineers and Landscape Architects

The Department of Administration (DOA) intends to retain the services of qualified professionally registered architects, engineers and landscape architects, to design, prepare construction drawings and monitor construction of a number of projects during the year commencing July 1, 1987. These projects will be varied in nature and scope and will involve new construction, remodeling projects and facility studies. The cost of construction or remodeling projects will be less than \$400,000.00 and the fees associated with facility studies will be less than \$35,000.00. Particular emphasis will be placed on the background and experience of the firm on similar projects as well as the firm's geographic proximity to the project.



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## STATE CONTRACTS & ADVERTISED BIDS

Firms wishing to be considered for these projects are asked to submit a short brochure or resume consisting of no more than 10 pages giving qualifications and experience of the firm to the Division of State Building Construction, Room G-10, State Administration Building, St. Paul, Minnesota 55155, **Attention: George Iwan**. Qualified applicants will be contacted as the need arises and may be requested to appear in St. Paul for an interview. Firms which responded during the past year need only respond with a letter indicating continued interest as well as significant organization and experience changes since submission of their last brochure.

In submitting their brochures or resumes, firms shall indicate the area or areas of the list shown below in which they feel qualified.

- |                             |                              |                            |                                |
|-----------------------------|------------------------------|----------------------------|--------------------------------|
| 1) Research and Programming | 5) Restoration               | 9) Arts, including         | 13) Water and Waste Facilities |
| 2) Educational              | 6) Office and Administration | Performing Arts            | 14) Energy Supply and          |
| 3) Health and Medical       | 7) Recreational              | 10) Exhibition and Display | Distribution                   |
| 4) Correctional             | 8) Service and Industrial    | 11) Landscape and Site     | 15) Pollution Control          |
|                             |                              | Planning                   | 15) Acoustics                  |
|                             |                              | 12) Interiors              |                                |

In some cases, DOA may enter into annual contracts for investigative studies, these annual contracts will be prepared on the basis of the needs of DOA.

The name of firms responding will be provided to other State Agencies having a need for the services described herein.

Names of qualified firms will be retained on file with DOA until June 30, 1988.

Designers for projects with estimated costs or fees in excess of those shown above will be selected by the State Designer Selection Board. Projects referred to the Board will be advertised in the *State Register*.

### Department of Administration Division of State Building Construction

#### Contracts Available for Registered Professional Testing Services

The Department of Administration (DOA) intends to retain the services of qualified professionally registered individuals to conduct site surveys, materials testing and soil borings and tests during the year commencing July 1, 1987. These projects will be varied in nature and scope. The fees associated with these projects will generally be less than \$2,000.00, although the fees for some projects may exceed this amount.

As projects arise, it is the intention of DOA to contact firms who have expressed an interest in providing such services to the State. The final selection will be made on the basis of the background and experience of the firm, the geographic proximity of the firm to the project site, and an estimate of the fees to be charged for the specific project. Such estimates will be requested when a specific project exists.

Firms wishing to be considered for these projects are asked to submit a short brochure or resume consisting of no more than 10 pages outlining their background, qualifications, and fields of expertise to the Division of State Building Construction, Room G-10, State Administration Building, St. Paul, Minnesota 55155, **Attention: George Iwan**. Qualified applicants will be contacted as the need arises and may be requested to appear in St. Paul for an interview.

Firms which have previously responded to this request need only provide a letter expressing continued interest as well as significant organization and experience changes since submission of their last brochure.

Names of qualified firms will be retained on file with DOA until June 30, 1988. Names of firms will be provided to other State Agencies having a need for the services described herein.

### Department of Corrections Minnesota Correctional Facility—Red Wing

#### Notice of Availability of Contract for Catholic Chaplain

The program at the Minnesota Correctional Facility—Red Wing requires the services of an ordained Catholic priest from 7/1/87 to 6/30/88. This person will provide weekly Mass and spiritual guidance and counseling for the Catholic students at MCF—Red Wing as requested. This person will provide up to 20 hours per week for 50 weeks at \$10.50 per hour. Annual cost is limited to \$10,500.00.

## STATE CONTRACTS & ADVERTISED BIDS

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For further information on these contracts, contact:

Kenneth Williams, Assistant Superintendent  
Minnesota Correctional Facility—Red Wing  
1079 Highway 292  
Red Wing, Minnesota 55066  
Telephone: (612) 388-7154

Final submission date for these contracts is: May 1, 1987.

### **Notice of Availability of Contract for Certified Driver Education Instructor Services**

The program at the Minnesota Correctional Facility requires the services of a certified driver education instructor. This position requires up to 60 hours per month of instruction. Responsibilities include classroom and behind-the-wheel instruction, testing and record keeping. The instructor shall provide a safety certified driver education car. The instructor would also be required to provide special instruction to students on a special need basis. Hours of instruction will be coordinated with general school schedules. Payment is \$10.00/hour. Annual cost would be limited to \$7,200.00.

For further information on this contract, contact:

John Odden, Director of Education  
Minnesota Correctional Facility—Red Wing  
1079 Highway 292  
Red Wing, Minnesota 55066  
Telephone: (612) 388-7154

Final submission date for this contract is May 1, 1987.

### **Notice of Availability of Contract for Dietetic Services**

The program at the Minnesota Correctional Facility—Red Wing requires the services of a licensed dietician. This person will provide professional dietetic consultation, enabling dietetic staff to provide hygienic dietetic services that meet the daily nutritional needs of residents, ensures that special dietary needs are met, and provides palatable, attractive and acceptable meals. The consultant will provide a minimum of 12 hours per month of professional services. Annual cost is limited to \$3,000.00.

For further information on this contract, contact:

Richard F. Ottoson, Business Manager  
Minnesota Correctional Facility—Red Wing  
1079 Highway 292  
Red Wing, Minnesota 55066  
Telephone: (612) 388-7154

Final submission date for this contract is May 1, 1987.

### **Notice of Availability of Contract for Medical Clinic Services**

The Program at the Minnesota Correctional Facility—Red Wing requires the services of a medical clinic. This clinic will provide all clinic services as ordered by the medical staff at MCF—Red Wing. Annual cost is limited to \$9,500.00.

### **Notice of Availability of Contract for Psychological Evaluation Services**

The program at the Minnesota Correctional Facility—Red Wing requires the services of a licensed psychologist. This person will provide the written psychological evaluation—through testing, interviews, etc., on up to a twice weekly basis for all new admissions to the institution, to re-test selected youths based upon specific staff referral, plus limited staff training in the area of his/her expertise. Payment is \$269.47 per 8-hour day. Annual cost is limited to \$25,600.00.

### **Notice of Availability of Contract for Volunteer Services Coordinator**

The program at the Minnesota Correctional Facility—Red Wing requires the services of a volunteer coordinator. Position requires up to 50 hours per week. Responsibilities include the providing of professional volunteer services for juvenile clients at the institution through the recruiting and training of volunteers, plus the development of a coordinated scheduling of the volunteers, plus the development of a coordinated scheduling of the volunteers to augment the on-going programs. Payment is \$2,055.00 per month. Annual cost is limited to \$24,660.00.

## **Minnesota Pollution Control Agency**

### **Request for Proposals for Analytical Services of Acid Precipitation Samples.**

The Minnesota Pollution Control Agency is seeking proposals from qualified firms to analyze acid precipitation samples for the biennium starting July 1, 1987. The Agency operates an acid precipitation monitoring network throughout the state and gathers approximately 650 wet and dry samples annually. The samples are analyzed for a host of parameters. The data obtained from the analyses of these samples have been used in the past to develop an acid deposition standard. Data from current sample analyses are being used to determine compliance with the acid deposition standard, to facilitate ongoing research, and to assess long term trends of acid precipitation in Minnesota.

The proposal should address the contactor's laboratory capabilities, proposed analytical methods, quality assurance and quality control, instrument maintenance and calibration, data reduction and reporting, sample handling, analyses turnaround, and costs. Information on any laboratory certifications that the contractor possesses should be reported in the proposal.

Interested parties may request a detailed Request for Proposals by calling or writing to:

Gary Eckhardt  
Supervisor, Air Monitoring Unit  
Minnesota Pollution Control Agency  
Division of Air Quality  
520 Lafayette Road  
St. Paul, Minnesota 55155  
(612) 296-7802

Proposals are due in Mr. Eckhardt's office no later than 4:30 p.m. thirty (30) days following the date of publication of this Request in the *State Register*.

The actual cost of the analyses performed by the contractor will depend upon the extent of funding of the Legislature, the number of valid wet samples collected (function of precipitation), the number of valid dry deposition samples collected, the extent of the Quality Assurance program, and the contractor's costs per sample analyzed. The Agency anticipates that the maximum cost of this contract to be \$140,000 spread over the biennium.

## **Department of Public Safety Office of Traffic Safety**

### **Request for Proposals for Motorcycle Rider Training Program**

The Department of Public Safety is seeking proposals to plan and conduct the Minnesota Motorcycle Rider Training Program; a statewide effort to increase the skills of novice riders and experienced riders and to train rider instructors. Details of the plan are contained in a Request for Proposals which may be obtained by writing or calling:

Susan J. Palmer  
Department of Public Safety  
Office of Traffic Safety  
207 Transportation Building  
St. Paul, MN 55155  
(612) 296-8512

Estimated cost of the contract is \$160,000.00. Final date for submitting proposals is April 6, 1987 by 4:00 p.m.

## **State University System Metropolitan State University**

### **Request for Proposal for Conducting an Analysis of its Faculty Computing Needs**

The purpose of the analysis is to provide recommendations for future hardware and software purchases for faculty computing, including 1) a list of, and detailed specifications for, all required resources (terminals, cables, communications equipment, file servers, etc.); and 2) costs of equipment, installation, maintenance, operation, training and for appropriate operations and systems documentation.

# STATE CONTRACTS & ADVERTISED BIDS

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## SCOPE OF THE PROJECT

The contractor will be asked to develop proposals for faculty computing capabilities that address the following issues:

- secure telecommunications capabilities,
- access to student records on the present Data General system,
- ability to carry out the tasks outlined in the RFP,
- capability for expansion and for changing to meet different needs, and
- costs and problems associated with move to a different physical location,
- projected load on the Data General system, and
- compatibility with faculty and member's personal home computers.

## PROJECT START AND COMPLETION DATES

Project is expected to begin upon award of contract. The university expects this study to be completed by June 15, 1987.

## PROJECT COSTS

The university expects this study to be conducted at a cost from \$4000. but not to exceed \$8000.

Copies of the Request for Proposal for Contract Services including the detailed project tasks are available from:

Leah Harvey  
Dean of Curriculum, Instruction & Assessment  
Metropolitan State University  
121 Metro Square Building  
St. Paul, MN 55101  
(612) 296-4449

All proposals must be submitted to Metropolitan State University no later than 2:00 pm, Monday, April 6, 1987.

## Department of Transportation Technical Services Division Research Administration and Development Section

### Notice of Availability of a Contract for Investigation of Man-made Floatable Litter Entering Waterways Through Storm Sewers

The Department of Transportation, acting as the agent for the Local Road Research Board, requires the services of a consultant for an investigation of man-made floatable litter entering waterways from storm sewers. The study would evaluate the type and amount of man-made floatable litter directly attributable to storm sewers, determine what percent of the total that is, and determine the relative effect of eliminating this contribution. The study would also propose and evaluate engineering methods to eliminate or mitigate these floatables and determine their cost effectiveness.

The Local Road Research Board has budgeted \$33,000 for this 15-month project.

Those interested may obtain a "Request for Proposal" from:

Gabriel S. Bodoczy, P.E.  
Research Services Engineer  
Mn/DOT Research Administration and  
Development Section  
Room B-9, Transportation Building  
St. Paul, Minnesota 55155  
Telephone: (612) 296-4925

Request for Proposals will be available through April 10, 1987.

All proposals will be due no later than April 17, 1987.

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In addition to requests by state agencies for technical/professional services (published in the State Contracts section), the *State Register* also publishes notices about grant funds available through any agency or branch of state government. Although some grant programs specifically require printing in a statewide publication such as the *State Register*, there is no requirement for publication in the *State Register* itself.

Agencies are encouraged to publish grant notices, and to provide financial estimates as well as sufficient time for interested parties to respond.

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## Department of Energy and Economic Development Community Development Division

### Final Statement for the 1987 Small Cities Community Development Block Grant Program

Notice is hereby given that the Department of Energy and Economic Development, Community Development Division, has prepared and submitted to the U.S. Department of Housing and Urban Development a Final Statement for the 1987 Small Cities Community Development Block Grant (CDBG) Program. Comments pertaining to the Final Statement were solicited in the *State Register* on January 5, 1987. A public hearing to receive comments was conducted on January 20, 1987.

#### CHAPTER 4300 COMMUNITY BLOCK GRANTS

##### 4300.0100. Definitions

Subp. 1. **Scope.** As used in this chapter, the following terms have the meanings given them:

Subp. 2. **Application Year.** "Application year" means the federal fiscal year beginning October 1st and ending September 30th.

Subp. 3. **Community Development Need.** "Community development need" means a demonstrated deficiency in housing stock, public facilities, economic opportunities, or other services which are necessary for developing or maintaining viable communities.

Subp. 4. **Competitive Grant.** "Competitive grant" means a grant application that is evaluated and ranked in comparison to other applications in the same grant category and includes housing, public facilities and comprehensive applications.

Subp. 5. **Comprehensive Program.** "Comprehensive program" means a combination of at least two interrelated projects which are designed to address community development needs which by their nature require a coordination of housing, public facilities, or economic development activities. A comprehensive program must be designed to benefit a defined geographic area, otherwise known as a program area.

Subp. 6. **Economic Development Project.** "Economic development project" means one or more activities designed to create new employment, maintain existing employment, increase the local tax base, or otherwise increase economic activity in a community.

Subp. 7. **Eligible Activities.** "Eligible activities" means those activities so designated in United States Code, title 42, section 5305 (1981) and as described in Code of Federal Regulations, title 24, sections 570.200-570.207 (1981).

Subp. 8. **General Purpose Local Government.** "General purpose local government" means townships as described in Minnesota Statutes, chapter 365; cities as described in Minnesota Statutes, chapters 410 and 412; and counties.

Subp. 9. **Grant.** "Grant" means an agreement between the state and an eligible recipient through which the state provides funds to carry out specified programs, services, or activities.

Subp. 10. **Grant Closeout.** "Grant closeout" means the process by which the office determines that all applicable administrative actions and all required work have been completed by the grant recipient and the department.

Subp. 11. **Grant Year.** "Grant year" means any period of time during which the United States Department of Housing and Urban Development makes funds from any federal fiscal year available to the state for distribution to local governments under United States Code, title 42, sections 5301-5316 (1981), and includes the period of time during which the office solicits applications and makes grant awards.

Subp. 12. **Infrastructure.** "Infrastructure" means the basic physical systems, structures, and facilities, such as roads, bridges, water, and sewer, which are necessary to support a community.

Subp. 13. **Low- and Moderate-income.** "Low- and moderate-income" means income which does not exceed 80 percent of the median income for the area, with adjustments for smaller and larger families.

Subp. 14. **Metropolitan City.** "Metropolitan city" means a city over 50,000 population or a central city of a standard metropolitan statistical area that receives entitlement grants under United States Code, title 42, section 5306 (1981) directly from the United States Department of Housing and Urban Development.

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Subp. 15. **Nonentitlement Area.** "Nonentitlement area: means an area that is not a metropolitan city or part of an urban county.

Subp. 16. **Office.** "Office" means the office or division in the Department of Energy and Economic Development to which the program is assigned.

Subp. 17. **Per Capita Assessed Valuation.** "Per capita assessed valuation" means the adjusted assessed valuation divided by population.

Subp. 18. **Population.** "Population" means the number of persons who are residents in a county, city, or township as established by the last federal census, by a census taken pursuant to Minn. Stat. § 275.53, subd. 2, by a population estimate made by the Metropolitan Council, or by the population estimate of the state demographer made under Minn. Stat. § 4.12, subd. 7, clause (10), whichever is most recent as to the stated date of count or estimate, up to and including the most recent July 1.

Subp. 19. **Poverty Persons.** "Poverty persons" means individuals or families whose incomes are below the poverty level as determined by the most current data available from the United States Department of Commerce, taking into account variations in cost of living for the area affected.

Subp. 20. **Program.** "Program" means the community development block grant program for nonentitlement areas.

Subp. 21. **Program Area.** "Program area" means a defined geographic area within which an applicant has determined that, based on community plans or other studies, there exists a need for community development activities. A program area may be a neighborhood in a community or an entire community.

Subp. 22. **Program Income.** "Program income" means gross income earned by the grant recipient from grant-supported activities, excluding interest earned on advances.

Subp. 23. **Project.** "Project" means one or more activities designed to meet a specific community development need.

Subp. 24. **Regional or Community Development Plans.** "Regional or community development plans" means written documents, resolutions, or statements which describe goals, policies, or strategies for the physical, social, or economic development of a neighborhood, community, or substate area. Regional or community development plans include comprehensive plans and elements of comprehensive plans, including land use plans, which have been approved by the governing boards of townships, counties, or cities, and also include regional development plans adopted under Minn. Stat. § 462.281, where applicable.

Subp. 25. **Slums and Blight.** "Slums and blight" means areas or neighborhoods which are characterized by conditions used to describe deteriorated areas in Minn. Stat. § 462.421 or which are characterized by the conditions used to describe redevelopment districts in Minn. Stat. § 273.73, subd. 10.

Subp. 26. **Single-purpose Project.** "Single-purpose project" means one or more activities designed to meet a specific housing or public facilities community development need.

Subp. 27. **Urban County.** "Urban county" means a county which is located in a metropolitan area and is entitled to receive grants under United States Code, title 42, section 5306 (1981), directly from the United States Department of Housing and Urban Development.

**Statutory Authority:** MS s 116K.04; 116K.06; 116K.07

**History:** 8 SR 1263

### 4300.0200. Purpose

This chapter gives procedures for evaluating applications for grants and awarding them to eligible applicants by the Department of Energy and Economic Development under United States Code, title 42, sections 5301-5136 (1981), and regulations adopted in Code of Federal Regulations, title 24, part 570.

**Statutory Authority:** MS s 116K.04; 116K.06; 116K.07

**History:** 8 SR 1263.

### 4300.0300. Objective of the Program

The primary objective of this program is to develop viable urban communities by providing decent housing and a suitable living environment and by expanding economic opportunities, principally for persons of low- and moderate-income. Activities funded under this program shall not benefit moderate-income persons to the exclusion of low-income persons. All funded activities must be designed to:

- A. Benefit low- and moderate-income persons;
- B. Prevent or eliminate slums and blight; or

C. Alleviate urgent community development needs caused by existing conditions which pose a serious and immediate threat to the health or welfare of the community where other financial resources are not available to meet those needs.

**4300.0400. Application of Federal Law**

If it is determined that any provisions of parts 4300.0100 to 4300.3200 are inconsistent with federal law controls to the extent necessary to eliminate the conflict.

**Statutory Authority:** MS s 116K.06; 116K.07

**GRANT APPLICATION, EVALUATION, AND DETERMINATION****4300.1100. Types of Competitive Grants Available**

**Subp. 1. Single-purpose Grants.** The office shall approve single-purpose grants for funding from a single grant year for single-purpose projects. The office shall place single-purpose grant applications in one of the following categories for purposes of evaluation:

A. Housing projects which include one or more activities designed to increase the supply or quality of dwellings suited to the occupancy of individuals and families; or

B. Public facilities projects which include one or more activities designed to acquire, construct, reconstruct, or install buildings or infrastructure which serve a neighborhood area or community.

**Subp. 2. Comprehensive Grants.** The office shall approve comprehensive grants for two or more projects which constitute a comprehensive program. Comprehensive grants shall be approved for funding from one, two, or three grant years. In the case of grants approved for funding from more than one grant year, the office shall make funds available to the grant recipient in the second or third year only after the recipient submits an approved application. Approval shall be subject to a finding by the office that the grant recipient has made normal progress and is in compliance with this chapter.

**Subp. 3. Previous Grant Commitments.** The provisions of Subp. 2 apply to three-year comprehensive grant commitments made by the United States Department of Housing and Urban Development in 1981 under United States Code, title 42, section 5306 (1980).

**Statutory Authority:** MS s 116K.04; 116K.06; 116K.07

**History:** 8 SR 1263

**4300.1101. Economic Development Grants, Noncompetitive**

The office shall approve grants for economic development projects for funding throughout a single application year, or until the funds reserved have been exhausted.

**Statutory Authority:** MS s 116K.04; 116K.06; 116K.07

**History:** 8 SR 1263

**4300.1200. Application Process and Requirements**

**Subp. 1. Grant Application Manual.** The office shall prepare a manual for distribution to eligible applicants no later than 120 days before the application closing date. The manual must instruct applicants in the preparation of applications and describe the method by which the office will evaluate and rank applications. If this chapter is not adopted before September 15, 1982, the 120-day period is waived for the 1983 grant year but the office shall make the manual available no later than 60 days before the application closing date.

**Subp. 2. Eligibility Requirements.** Any unit of general purpose local government, including cities, counties, and townships located in a nonentitlement area or electing exclusion from an urban county under United States Code, title 42, section 5302 (1981), may apply for a grant. An eligible applicant may apply on behalf of other eligible applicants. Applications submitted on behalf of other applicants must be approved by the governing body of all local governments party to the application. An eligible applicant may apply for only one competitive grant per grant year and no eligible applicant shall be included in more than one competitive application. An eligible applicant may apply for one economic development grant in addition to a competitive grant each application year.

**Subp. 3. Disqualification of Applicants.** Applications from otherwise eligible applicants shall be disqualified where for previously awarded grants under these rules or awarded by the Department of Housing and Urban Development under United States Code, title 42, section 5306 (1981), it is determined by the office that any of the following conditions exist:

A. There are outstanding audit findings on previous community development grants and the grantee has not objected on a reasonable basis to the findings or demonstrated a willingness to resolve the findings;

B. Previously approved projects have passed scheduled dates for grant closeout and the grantee's ability to complete the project in an expeditious manner is in question; or

C. The applicant has not made scheduled progress on previously approved projects and the grantee's ability to complete the project in an expeditious manner is in question.

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Subp. 4. **Contents of Application.** The contents of the application must be consistent with the informational requirements of this chapter and must be on a form prescribed by the office. The application must be accompanied by:

- A. An assurance, signed by the chief elected official, that the applicant will comply with all applicable state and federal requirements;
- B. An assurance signed by the chief elected official certifying that at least one public hearing was held at least ten days but not more than 60 days before submitting the application; and
- C. A copy of a resolution passed by the governing body approving the application and authorizing execution of the grant agreement if funds are made available.

The office may request additional information from the applicant if it is necessary to clarify and evaluate the application.

Subp. 5. **Time Limit for Submitting Applications.** Competitive applications must be received in the office or postmarked by the closing date. The office shall give notice of the period during which applications will be accepted. The notice must be published in the *State Register* at least 120 days before the closing date. Economic development project applications may be submitted at any time during the grant year.

Subp. 6. **Regional Review.** The applicant must submit a complete copy of the application to the Regional Development Commission, where such a commission exists, or the Metropolitan Council, where it has jurisdiction, for review and comment in accordance with Minn. Stat. § 462.391, subd. 3, or Minn. Stat. § 473.171, respectively.

**Statutory Authority:** MS s 116K.04; 116K.06; 116k.07

**History:** 8 SR 1263

### 4300.1300. Evaluation of Applications

All applications shall be evaluated by the office. A fixed amount of points shall be established as the maximum score attainable by any application. Points shall be made available within each class of rating criteria in accordance with the percentages and fractions indicated in 4300.1400 to 4300.1900. Economic development project applications must meet threshold criteria in order to be evaluated.

**Statutory Authority:** MS s 116K.04; 116k.04; 116K.06; 116K.07

**History:** 8 SR 1263

### 4300.1400. Comparison of all Competitive Applications, General Competition

Subp. 1. **Points Available.** Thirty percent of the total available points shall be awarded by the office based on a general competition involving a comparison of all applications.

Subp. 2. **Evaluation of Community Need.** Two-thirds of the points in the general competition shall be awarded based on evaluation of community need, which shall include:

- A. The number of poverty persons in the area under the applicant's jurisdiction;
- B. The percentage of persons resident in the area under the applicant's jurisdiction who are poverty persons; and
- C. The per capita assessed valuation of the area under the jurisdiction of the applicant, such that points are awarded in inverse relationship to applicants' per capita assessed valuation.

Subp. 3. **Evaluation of Other Factors.** One-third of the points in the general competition shall be awarded based on evaluation of:

- A. The extent to which the proposed activities are compatible with regional or community development plans; and
- B. Adequacy of the applicant's management and financial plan.

**Statutory Authority:** MS s 116K.04; 116K.06; 116K.07

**History:** 8 SR 1263

### 4300.1500 Comparison of Competitive Applications Within Categories

After completing the general competition described in 4300.1400, the office shall place each application in the appropriate grant category in accordance with part 4300.1100. The categories are housing projects, public facilities projects, economic development projects, and comprehensive programs. Seventy percent of the total points available for each application shall be awarded based on a comparison of the applications within each of the categories, as further described in parts 4300.1600 to 4300.1900.

**Statutory Authority:** MS s 116K.04; 116K.06; 116K.07

**History:** 8 SR 1263



**4300.1600. Evaluation of Housing Projects**

Subp. 1. **Project Need.** Three-sevenths of the points available in the housing category competition shall be awarded by the office based on evaluation of the need for improvements or additions to the housing stock serving low- and moderate-income persons as evidenced by:

- A. Housing units which are occupied by low- and moderate-income persons and are either substandard or pose a threat to the health or safety of the occupants;
- B. An inadequate supply of affordable housing for low- or moderate-income persons; or
- C. Other documented conditions which give evidence of the need for improvements or additions to the housing stock serving low- and moderate-income persons.

Subp. 2. **Project Impact.** Three-sevenths of the points available in the housing category competition shall be awarded by the office based on evaluation of the extent to which the proposed activities will eliminate or reduce the need for improvements or additions to the housing stock serving low- or moderate-income persons.

Subp. 3. **Project Cost-effectiveness.** One-seventh of the points available in the housing category competition shall be awarded by the office based on:

- A. Evaluation of the extent to which the proposed activities will make cost effective and efficient use of grant funds including coordination with, and use of, funds from other public and private sources; and
- B. Evidence that the cost of the proposed activities per benefitting household is reasonable.

**Statutory Authority:** MS s 116K.06; 116K.07

**4300.1700. Evaluation of Public Facilities Projects**

Subp. 1. **Project Need.** Three-sevenths of the points available in the public facilities category competition shall be awarded by the office based on evaluation of the extent to which the proposed activities are necessary to improve provision of public services to low- and moderate-income persons or to eliminate an urgent threat to public health or safety.

Subp. 2. **Project Impact.** Three-sevenths of the points available in the public facilities category competition shall be awarded by the office based on evaluation of the extent to which the proposed activities will reduce or eliminate the need identified under Subp. 1, and, in the case of activities designed to improve the provision of public services to low- and moderate-income persons, an evaluation of the extent to which the proposed activities directly benefit low- and moderate-income persons.

Subp. 3. **Project Cost-effectiveness.** One-seventh of the points available in the public facilities category competition shall be awarded by the office based on evaluation of the extent to which the proposed activities will make cost effective and efficient use of grant funds, including consideration of:

- A. The extent to which the requested grant funds are necessary to finance all or a portion of the costs;
- B. Evidence that the cost of the proposed activities per benefitting household or person is reasonable; and
- C. The extent to which the project benefits existing, rather than future, population, except in cases where the proposed activities are necessary due to expected development or growth which is beyond the applicant's control.

**Statutory Authority:** MS s 116K.06; 116K.07

**4300.1900. Evaluation of Comprehensive Program Projects**

Subp. 1. **Program Need.** Three-sevenths of the points available in the comprehensive program category competition shall be awarded by the office based on evaluation of need for the proposed comprehensive program, including consideration of:

- A. The number of low- and moderate-income persons in the program area;
- B. The percentage of residents in the program area which are of low- or moderate-income; and
- C. The need for the proposed comprehensive program as evidenced by at least two of the following: the need for improvements or additions to the housing stock serving low- and moderate-income persons, the need for new or improved public facilities in the program area, or employment problems in the program area.

Subp. 2. **Program Impact.** Three-sevenths of the points available in the comprehensive program category competition shall be awarded by the office based on evaluation of the extent to which the proposed comprehensive program will eliminate or reduce the need identified under Subp. 1, and the extent to which the proposed program will improve the long-term physical or economic condition of the program area and its residents.

Subp. 3. **Program Cost-effectiveness.** One-seventh of the points available in the comprehensive program category competition

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shall be based on evaluation of the extent to which the proposed comprehensive program will make cost effective and efficient use of grant funds, including consideration of coordination with, and use of, funds from other public and private sources.

**Statutory Authority:** MS s 116K.06; 116K.07

### 4300.1901. Evaluation of Economic Development Projects

Subp. 1. **In General.** Evaluation of economic development applications consists of eligibility threshold screening and project review. Applications must meet the eligibility thresholds in order to be referred for project review. Applications that fail to meet eligibility thresholds may be revised and resubmitted.

Subp. 2. **Federal and State Eligibility Thresholds.** Applicants shall provide a description of the ways that activities address one of the federal objectives described in Part 4300.0300. Each activity proposed for funding must be eligible under current federal regulations.

Applicants shall describe how they will meet two of the three following thresholds based on state economic development objectives:

- A. Creation or retention of permanent private sector jobs;
- B. Stimulation or leverage of private investment; or
- C. Increase in local tax base.

Subp. 3. **Project Review.** Applications that meet eligibility thresholds will be awarded points by the office based on evaluation of the two rating categories: project design and financial feasibility. Applications must attain at least two-thirds of the total available points for economic development to be recommended for funding. Applications must score at least half of the points available in each of the two rating categories.

Two-thirds of the available points will be awarded based on an evaluation of project quality including an assessment of need, impact, and the capacity of the applicant to complete the project in a timely manner. Consideration of need for an economic development project must be based on deficiencies in employment opportunities and circumstances contributing to economic vulnerability and distress. Consideration of impact must be based on the extent to which the project reduces or eliminates the need. Consideration of capacity must be based on demonstration of administrative capability, realistic implementation schedules, and the ability to conform to state and federal requirements.

One-third of the available points will be awarded based on an evaluation of the effective use of program funds to induce economic development. Consideration of financial feasibility must include investment analysis, commitment of other funds, and other factors relating to the type of program assistance requested.

Subp. 4. **Funding Recommendations.** Applications that attain at least two-thirds of the available points will be recommended to the commissioner for funding. Applications not recommended for funding may be revised and resubmitted.

**Statutory Authority:** MS s 116K.04; 116K.06; 116K.07

**History:** 8 SR 1263

### 4300.2000. Determination of Grant Awards.

Subp. 1. **Funds Available for Grants.** The amount of funds available for grants shall be equal to the total allocation of federal funds made available to the State under United States Code, title 42, section 5306 (1981), after subtracting an amount for costs available by the office for administration of the program, as allowed by that law. The office is not liable for any grants under this chapter until funds are received from the United States Department of Housing and Urban Development.

Subp. 2. **Division of Funds.** Of the funds available for grants in each grant year, 30 percent shall be reserved by the office to fund single-purpose grants, 15 percent shall be reserved for economic development grants, and 55 percent shall be reserved by the office to fund comprehensive grants, including the second and third years of comprehensive grants approved for funding under Parts 4300.1100 and 4300.1900. However, the office may modify the proportions of funds available for single-purpose and comprehensive grants if, after review of all applications, it determines that there is a shortage of fundable applications in either category.

At least 30 percent of the funds made available for single-purpose grants shall be awarded for applications in each of the two categories: housing and public facilities. However, no application with a rating below the median score for its category shall be funded by the office solely for the purpose of meeting this requirement.

If there are unawarded economic development funds available at the end of the application year, two-thirds of the remaining funds will be available for competitive single-purpose projects and one-third will be available for economic development projects during the next application year.

Subp. 3. **Funding List.** Within each grant category, a list of applications shall be prepared in rank order of the scores received after evaluation pursuant to Parts 4300.1300 to 4300.1900. Based on these lists, and subject to the availability of funds within each

category, applications with the highest rank shall be recommended to the commissioner for funding. In the case of a tie between any two applications within any category, the application with the higher score in the general competition shall receive the higher ranking on the list.

Subp. 4. **Approval by Commissioner.** The list of applications recommended for funding, including recommended grant awards, shall be submitted by the office to the commissioner for approval. A decision by the commissioner not to approve any application recommended for funding must be made in writing to the applicant, giving reasons for disapproval.

Subp. 5. **Reduction in Amount Requested.** The office may recommend an application for funding in an amount less than requested if, in the opinion of the office, the amount requested is more than is necessary to meet the applicant's need. If the amount of the grant is reduced, the reasons for the reduction shall be given to the applicant.

Subp. 6. **Grant Ceilings.** No competitive single-purpose grant may be approved for an amount over \$600,000. No comprehensive grant may be approved for an amount over \$700,000 from any single grant year or for more than a total of \$1,400,000 over three grant years. No economic development grant may be approved for over \$500,000.

**Statutory Authority:** MS s 116K.04; 116K.06; 116K.07

**History:** 8 SR 1263

## **CONTRACTS AND RECORDS**

### **4300.3100. Grant Agreements**

Subp. 1. **Grant Contract Required.** A grant contract shall be offered to each applicant whose application is approved for funding. The contract must be signed by a person authorized to commit the applicant to legally binding agreements and to execute the contract.

Subp. 2. **Contents of Grant Contract.** The grant contract must include:

A. A work program which indicates completion dates for major parts of the project and a projected budget supporting the work program;

B. A description of the manner in which payments will be made to grant recipients with the condition that five percent of the grant award will not be paid until successful completion of all activities in the work program; and

C. Assurances that the grant recipient will comply with all applicable state and federal laws, including at least the federal laws or regulations for which the state is made responsible for enforcement in Code of Federal Regulations, title 24, sections 570.495 and 570.496.

Subp. 3. **Use of Program Income.** Income from sources such as reimbursements to and interest from a grant recipient's loan program, proceeds from disposition of real property, and proceeds from special assessments must be used for project-related costs within 12 months from the time it is earned. The office shall reduce future grant payments by the amount of any unobligated income which an applicant has and shall take whatever additional action is necessary to recover any remaining amounts owed.

Subp. 4. **Grant Account Required.** Grant recipients must establish and maintain separate accounts for grant funds. In accordance with Code of Federal Regulations, title 24, section 570.494, clause 4, interest earned by grant recipients on grant funds before disbursement is not program income, and it must be returned to the United States Treasury.

Subp. 5. **Restrictions on Use of Funds.** No grant funds shall be used to finance activities not included in the grant agreement. If it is determined that an improper use of funds has occurred, the office will take whatever action is necessary to recover improperly spent funds.

Subp. 6. **Suspension of Payments.** The office shall suspend payment of funds to grant recipients which are not in compliance with applicable state and federal laws, rules, and regulations. Grant recipients must return funds which are improperly expended.

Subp. 7. **Amendments to the Agreement.** Amendments to the grant agreement must be in writing.

**Statutory Authority:** MS s 116K.06; 116K.07

### **4300.3200. Recordkeeping and Monitoring**

Subp. 1. **Financial Records.** Grant recipients shall maintain financial records which identify the source and application of funds for grant-supported activities. These records must contain information about grant awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays, income, and other information required by the office under the responsibilities it assumes under Code of Federal Regulations, title 24, section 570.497, clause b. Financial records, supporting documents, statistical records, and all other reports pertinent to a grant must be retained by the grant recipient for three years from the date of submitting the final financial report. No such records or documents may be disposed of while audits, claims, or litigations involving the records are in progress.

Subp. 2. **Audits.** Grant recipients must arrange for and pay for an audit before grant closeout. Audits will usually be done

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annually, but no less frequently than every two years. In the case of two and three year comprehensive programs, the office shall require an audit after two years; costs incurred pursuant to this requirement are eligible under this program.

Subp. 3. **Financial Status Reports.** Grant recipients shall file financial status reports at the close of each reporting period as designated by the office and shall file a final financial report before grant closeout. Financial status reports must be on forms prescribed by the office. The office may not require these reports more often than quarterly.

Subp. 4. **Performance Report.** Grant recipients shall also file performance reports at the close of each reporting period as designated by the office and shall file a final performance report before grant closeout. Performance reports shall be on forms prescribed by the office. The office may not require these reports more often than quarterly.

Subp. 5. **Access to Records.** Representative of the office, either the State Auditor or Legislative Auditor as is appropriate, and federal auditors shall have access to all books, records, accounts, files, and other papers, things, or property belonging to grant recipients which are related to the administration of grants and necessary for audits and monitoring compliance with Parts 4300.0100 to 4300.3200.

**Statutory Authority:** MS s 116K.06; 116K.07

## **Proposed Distribution of Funds**

The exact amount of Federal FY 1987 CDBG funds for use by the Small Cities Development Program is currently unknown. Under the administrative rules for this program, 15 percent, will be reserved for economic development grants; 30 percent, will be reserved for single-purpose housing or public facilities grants; and 55 percent, will be reserved for comprehensive grants. Two percent of the available funds will be used by DEED for administration of the grant program.

## **Proposed Use of Funds for Activities That Will Benefit Persons of Low- and Moderate-Income**

The purpose of the Small Cities Development Program is to develop viable urban communities by providing decent housing and a suitable living environment and by expanding economic opportunities, principally for persons of low and moderate income. Activities funded under this program shall not benefit moderate income persons to the exclusion of low-income persons. All funded activities must be designed to:

- a) Benefit low- and moderate-income persons;
- b) Prevent or eliminate slums and blight; or
- c) Alleviate urgent community development needs caused by existing conditions which pose a serious and immediate threat to the health or welfare of the community, where other financial resources are not available to meet those needs.

Under the Housing and Community Development Act of 1974, as amended, at least 51 percent of the funds must be used for activities that benefit low and moderate income persons. The Department of Energy and Economic Development, Community Development Division, estimates that up to 70 percent of the funds will be used to benefit persons of low and moderate income.

## **Recaptured and Reallocated Funds**

If FY'84 through FY'86 competitive grant funds are returned to the Minnesota Department of Energy and Economic Development, Community Development Division, following audit resolution or project closeout, the first priority for reuse of the funds will be to finance emergency, urgent need projects. Applications for emergency urgent need could be submitted at any time during the year. Following is the criteria under which emergency urgent-need projects could be funded:

- a) The problem poses a serious and immediate threat to the health or welfare of the community.
- b) The problem is of recent origin or has recently become urgent. To qualify for emergency, urgent-need funds, recent is defined to mean that a problem has to become urgent no earlier than 45 days before the last competitive application deadline.
- c) The applicant can document inability to finance the project on its own and other resources to finance the project are not available.
- d) The project would have to score well enough in the rating system to have received a grant, had an application been submitted during the last competitive cycle.

A balance of recaptured competitive FY'84 through FY'86 funds will be carried forward only until the point at which competitive grant awards are made. Any balance of recaptured or reallocated funds that exists at the time grants are awarded for the annual competitive grant cycle will be used to finance competitive projects.

Recaptured and reallocated FY'84 through FY'86 Economic Development Set-aside funds will be reserved for FY'87 economic development projects. Up to fifteen percent of FY'83 recaptured or reallocated Jobs Bill and Small Cities funds will be reserved for economic development projects. At least eighty-five percent of FY'83 Jobs Bill and Small Cities funds will be used in the same manner as that described for FY'84-86 competitive funds.

**Distribution of Program Income**

Any program income which is derived from the use of federal CDBG funds, is retained by the recipient communities. Thus, the state will not have the use of program income for distribution in FY'87.

**Description of the Use of Funds in the 1986 Small Cities Community Development Block Grant Program**

For the 1986 grant program \$17,788,920 in federal funds was available for grants to eligible applicants for the Small Cities Development Program. Under the administrative rules for the SCDP, economic development applications are accepted on a year-round basis and competitive single-purpose and comprehensive applications had an application deadline of January 31, 1986. The rules for the program established the availability of 15 percent of the funds for economic development, 30 percent of the funds for single-purpose projects, and 55 percent of the funds for comprehensive programs.

Upon completion of the competitive review and ranking process, 32 awards were made. The first round of grants was awarded on May 30, 1986. On that date, all available FY'86 Small Cities competitive funds were exhausted. Following the congressional overturn of a presidential deferral, four additional projects were funded and four projects that were partially funded on May 30, 1986, received additional funds. These awards were made on August 13, 1986. Thus, the total number of FY'86 competitive awards is now 36. Of all funds available in FY'86, 55% were awarded for comprehensive projects, 30% were awarded for single-purpose projects, and 15% were reserved for economic development projects. The Department of Energy and Economic Development concludes that funds were awarded in accordance with the State's administrative rules for the program.

**Assessment of the Relationship of 1986 Funds to State and Federal Objectives**

As in 1983, 1984, and 1985, for the 1986 grant program, the Minnesota Department of Energy and Economic Development, Community Development Division, adopted the national objectives for the Community Development Block Grant program. Under these objectives, all funded activities must be designed to:

- a) Benefit low- and moderate-income persons;
- b) Prevent or eliminate slums or blight; or
- c) Alleviate urgent community development needs caused by existing conditions, which pose a serious and immediate threat to the health or welfare of the community where other financial resources are not available to meet those needs.

Based on a total FY'86 grant award of \$18,254,000, at least 51%, or \$9,309,540, must be awarded for activities designed to benefit persons of low- and moderate-income. To date, with an unobligated FY'86 balance of just over \$1 million, DEED has already approved more than \$13 million for activities designed to benefit low- and moderate-income persons. Thus, even with a balance, DEED has already awarded well over 70 percent of our total FY'86 grant award for activities which benefit low- and moderate-income persons. The remainder of the funds currently awarded for grants has been awarded for activities designed to prevent or eliminate slums and blight. No FY'86 funds have been awarded for activities designed to alleviate urgent community development needs.

The funds budgeted for planning and administration include both the funds retained by the Minnesota Department of Energy and Economic Development for administration of the program and funds awarded to units of general local government for planning and administration of their grants. No more than 20 percent of the block grant can be used for planning and administration.

To date, for the 1986 grant program, the Minnesota Department of Energy and Economic Development, Community Development Division, and the 1986 grant recipients budgeted slightly less than \$1.0 million for planning and administration. These funds amount to just over five percent of the block grant, well below the 20.0 percent limit.

State objectives for the Small Cities Development Program apply to the economic development set aside only. Each grant awarded must meet two of the three state objectives listed below:

- a) Creation or retention of permanent private sector jobs, with a minimum threshold of one job created or retained for each \$20,000 of grant funds;
- b) Leverage of private investment, with a minimum threshold of one dollar private funds for each grant dollar requested; and
- c) Increase the local tax base, with a minimum threshold of an estimated 50 percent increase in the value of the parcel involved.

Of the federal economic development set aside funds awarded to date, all met the job creation or retention objective and also the private leverage threshold. Eight grants will leverage a total private investment of \$29 million (approximately 18 to 1 ratio) and create or retain 513 jobs, at an average grant cost of \$3,120 per job. Three grants met the tax base threshold. To meet the federal objective benefit to low and moderate income persons, at least 51 percent of the jobs proposed for each project had to be available to low and moderate income persons.

## STATE GRANTS

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Based upon analysis of the 1986 Small Cities Development Program, the Minnesota Department of Energy and Economic Development, Community Development Division, concludes that the 1986 grant program fully meets state and national objectives for award of funds.

### Lawyer Trust Account Board

#### Notice of Grant Cycle July 1, 1987 to June 30, 1988

The Minnesota Supreme Court has established a program to use the interest on lawyer trust accounts (IOLTA) to improve the delivery of legal services to the poor, to promote development of law-related education for the public, and to develop programs to enhance the administration of justice.

The Lawyer Trust Account Board has made grants in the amount of over \$4,000,000 to legal services organizations, to programs to enhance the administration of justice and to programs providing legal education for the public in its four prior grant cycles.

The Board is soliciting proposals to distribute funds to projects in any of the three program areas. The Board will support not only traditional approaches, but will encourage projects that show innovative approaches to recognized needs throughout the state. For application information, contact the Executive Director, 318 Capitol, St. Paul, MN 55155. The deadline for submitting applications is April 15, 1987.

13 February 1987

### State Board of Vocational Technical Education Instructional & Student Support Services

#### Notice of Availability of Funds for Handicapped Vocational Programs

The State Board of Vocational Technical Education will distribute federal funds to eligible recipients in accordance with the Carl D. Perkins Vocational Education Act for Handicapped to provide supplemental services/programs/activities necessary to succeed in vocational training programs. The amount of federal funds available for Handicapped Vocational Program Services and Activities is \$500,000.00.

Organizations and associations interested in applying for federal funds should contact the nearest AVTI for additional information or refer to Section 7.0 "Planning Use of Federal Funds" in the Fiscal Year 1987 Minnesota State Plan for Vocational Technical Education for information relating to the availability and disbursement of federal funds.

Qualified organizations and associations must prepare a joint application with an appropriate eligible recipient whose main responsibility will be to act as fiscal agent for distribution of and accountability for the federal funds.

An eligible recipient is defined as: a) a nonprofit educational recipient legally authorized to provide post-secondary or secondary vocational education; and b) have established certified vocational technical education programs.

Additional information will be included in the "Request for Proposal" which will be mailed upon request. To receive a Request for Proposal notify Lloyd A. Petri, 530 Capitol Square Building, 550 Cedar Street, St. Paul, Minnesota 55101 no later than 4:30 p.m. on April 24, 1987.

Final proposals must be submitted to the State Board of Vocational Technical Education, Instructional and Student Support Specialist Office, by 4:30 p.m. on May 1, 1987.

## SUPREME COURT DECISIONS

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### Decisions Filed Friday 6 March 1987

Compiled by Wayne O. Tschimperle, Clerk

**C6-85-2340 William Becker v. Alloy Hardfacing & Engineering Company, et al., petitioners, Appellants. Court of Appeals.**

Trial court's omission of jury instruction explaining "clear and convincing" evidence standard for awarding punitive damages was fundamental error resulting in prejudice to appellants.

Failure to raise evidentiary objection in motion for new trial precludes review.

Trial court's refusal to instruct jury on conditional privilege did not prejudice appellants where jury found appellants acted with actual malice.

General damages are presumed in action for defamation per se.

Compensatory damage award was not excessive as a matter of law.

Trial court should have stated reasons in denying motion for attorney fees.

Affirmed in part, reversed in part, and remanded. Amdahl, C.J.

**C3-86-250 Beverly Dorn v. Liberty Mutual Fire Insurance Company, petitioner, Appellant. Court of Appeals.**

The insurance policy limits for uninsured motorist coverage cannot be exhausted by the first claimant from a multiperson accident.

The extra coverage available to a later claimant is the \$25,000 required by statute.

Affirmed in part, reversed in part. Yetka, J.

**C4-86-371 Grant Gjovik v. Lawrence Strobe, petitioner, Appellant, Lawrence McKee, Martin Gubb, et al. Court of Appeals.**

The evidence sustained the trial court's finding that respondent Gjovik accepted appellant's withdrawal from partnership obligations.

Reversed. Yetka, J.

**C8-85-2372 In the Matter of the Application for the Discipline of Paris DonRay Getty, an Attorney at Law of the State of Minnesota. Supreme Court.**

Publicly reprimanded. Per Curiam.

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**TAX COURT**

Pursuant to Minn. Stat. § 271.06, subd. 1, an appeal to the tax court may be taken from any official order of the Commissioner of Revenue regarding any tax, fee or assessment, or any matter concerning the tax laws listed in § 271.01, subd. 5, by an interested or affected person, by any political subdivision of the state, by the Attorney General in behalf of the state, or by any resident taxpayer of the state in behalf of the state in case the Attorney General, upon request, shall refuse to appeal. Decisions of the tax court are printed in the *State Register*, except in the case of appeals dealing with property valuation, assessment, or taxation for property tax purposes.

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**Regular Division: Docket No. 4689****Findings of Fact, Conclusions of Law and Order for Judgment Dated: March 4, 1987****Richard L. Johnson (Pinetree Business Systems, Inc.), Appellant, vs. Commissioner of Revenue, Appellee.**

The above-entitled matter came on for hearing before the Honorable M. Jean Stepan, Judge of the Minnesota Tax Court, on February 25, 1987, at the Courtroom of the Tax Court, 520 Lafayette Road, St. Paul, Minnesota, pursuant to appellee's motion for an order summarily affirming the Order of the Commissioner of Revenue.

No appearance was made at the hearing by the appellant.

Neil F. Scott, Special Assistant Attorney General, appeared on behalf of appellee.

Based on the files, records and proceedings herein, the Court now makes the following:

**FINDINGS OF FACT**

1. Appellant, Richard L. Johnson, filed an appeal with the Minnesota Tax Court on September 10, 1986, contesting the personal liability for an assessment of sales taxes for Pinetree Business Systems, Inc. by an Order of appellee dated July 11, 1986.
2. Mr. Johnson failed to answer Interrogatories served upon him by appellee in October, 1986.
3. Subsequent to filing this appeal, Mr. Johnson met with representatives of the Commissioner of Revenue and indicated he did not contest the liability which is the subject of this appeal.
4. Mr. Johnson made no appearance at the hearing on this motion, and indicated to appellee's attorney prior to the hearing that he did not oppose appellee's motion.

**CONCLUSIONS OF LAW**

1. There are no genuine issues of material facts before the Court in this appeal.

2. The Order of the Commissioner of Revenue, dated July 11, 1986, is hereby affirmed.  
LET JUDGMENT BE ENTERED ACCORDINGLY. A STAY OF 15 DAYS IS HEREBY ORDERED.

BY THE COURT,  
M. Jean Stepan, Judge  
Minnesota Tax Court

**MEMORANDUM**

Although no appearance was made at the hearing by the appellant, he had indicated to the attorney for the appellee prior to the hearing that he did not oppose this motion. The appellant also indicated within two weeks prior to this hearing that he did not contest the liability at issue in this appeal. We are therefore granting appellee's motion to summarily affirm the Order of the Commissioner of Revenue from which this appeal was taken.

M.J.S.

# Minnesota: national leader in education

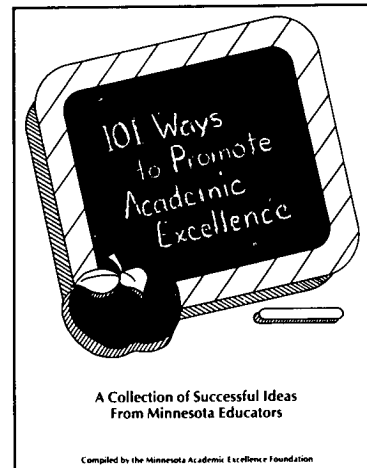
## 101 Ways to Promote Academic Excellence

A collection of nuts-and-bolts methods educators have successfully used to foster academic achievement. These are techniques that directly help students, can be replicated easily, are cost-effective, and that work in meeting public education's great challenge: helping every single child learn. Code #5-1, \$4.50.

## Education Directory, 1986-87

This popular comprehensive directory contains Minnesota school districts, superintendents, principals, addresses, phone numbers, and enrollment. 128 pages, paperbound. Code #1-93, \$5.00.

**TO ORDER:** Send to Minnesota Documents Division, 117 University Avenue, St. Paul, MN 55155. (612) 297-3000, or toll-free in Minnesota: 1-800-652-9747 and ask for "DOCUMENTS." Please include 6% sales tax, and \$1.50 postage and handling. Prepayment required. Please include daytime phone. VISA/MasterCard orders accepted over phone.

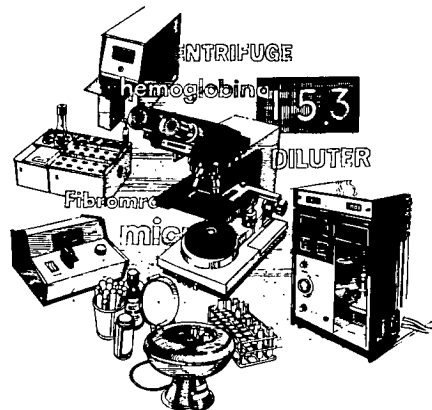


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# Buying Or Selling?

In either case, The Medical Alley Directory can help you do your job better. Double your business; the 1986 edition is nearly twice as large as last year's. Reach the decision-makers without delay at more than 300 medical and bio-tech companies and healthcare delivery organizations.

Entries include major products and/or services, company background, special interests, trade name(s), major activities, and addresses and phone numbers. Code # 40-7, \$49.95.



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# MAILING LISTS GALORE

## Successful business means successful sales

The Minnesota Documents Division has a variety of mailing lists of licensed professionals and permit holders that will enable you to focus your marketing efforts on a targeted audience.

Types of lists available are: registered nurses, real estate agents, physicians, insurance agents, boatowners, hunters, cosmetologists, teachers, and many more! And you can get them on printouts, cheshire/pressure sensitive labels, as well as 9-track magnetic tapes.

What's more, you can choose from several selection capabilities. You will find our selections most helpful and beneficial to your business when you learn that you can acquire names and addresses of individuals in the areas you need to target most.

Find out more about our mailing lists by writing for our free mailing list catalog. In a hurry? Call (612) 297-2552 for more information. Requests can be sent to: Minnesota Documents Division, Mailing List Operation, 117 University Avenue, St. Paul, MN 55155.

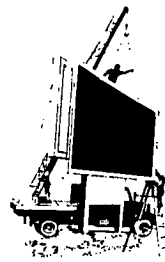
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## Minnesota Manufacturer's Directory 1986-87

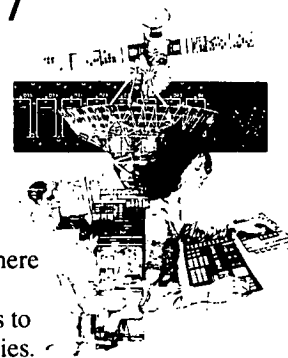


UPDATED: Name, address, phone number, staff size, sales volume, market area, year of establishment, type of firm, C.E.O., Sales or Marketing Manager, Purchasing Manager and four major manufactured products. Code #40-2, \$68.50.

NEW: In the directory this year are two titles (where applicable) Chief Engineer and Data Processing Manager.



REVISED: There are more than 7,000 changes to the 7,068 entries.



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## Voices of the Loon

Its voice severs the bonds to the world of cities, traffic, crowds, lights and noise. The lyrical magic of the loon, sometimes hauntingly eerie, makes the skin tingle, and the hair on the back of the neck stand on edge, awakening a primitive response. Its solitary wail turns the shadowy wilderness into a mysterious path into eternity.

*Voices of the Loon*, cassette tape, includes introduction and loon call identification, chorus from a distant lake, tremolo duet, wail duet, border confrontation, wails with morning songbird chorus, tremolos while running, wails during a thunderstorm, and coyotes calling with loons. Code #19-73, \$12.00.

*The Loon: Voice of the Wilderness*, hardbound with color plates and illustrations. 143 pages. Code #9-14, \$6.00.

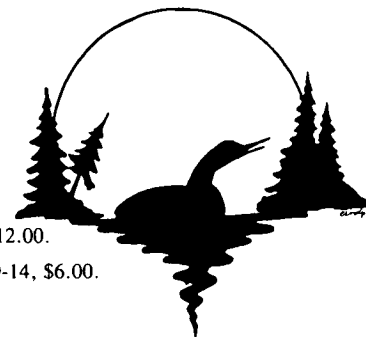
*Loon Calendar 1987*, beautiful photographs and scenes. Code #15-40, \$6.95.

*Loon Lapel Pin*. Code #15-30, \$2.49.

*Loon Windsock*, 56 inches long in full color. Code #15-29, \$19.95.

*Loon Nature Print*, full-color poster 16" x 22", Code #15-18, \$3.00.

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# Minnesota's future environment

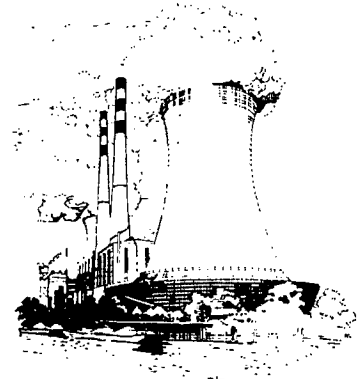
The issue of environmental protection is of continuing interest to both Minnesota business and the general public. Stay abreast of changes in state government regulations with these publications.

## 1986 Pollution Control Laws

Laws dealing with water pollution, disposal facilities, solid waste management, the MN Environmental Rights Act, recycling, and more. Code No. 2-21. \$15.00.

## 1986 Hazardous Waste Rules

Governs the production, storage, transportation and disposal of hazardous waste. MN Rules Chapter 7045 and 7046. Code No. 3-71. \$13.50.



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## 60% Discount on case lots of the 1986 Official Minnesota Hiway Map

Equip your sales force. Drive off with your Minnesota Highway maps for less than 20¢ each (regular retail price: 55¢ each). Discount applies to case lots only, with a minimum order of 1 case (200 maps) at \$39.95. Great for workshop folders, conventions and programs. Code #12-52.

**Hudson's Street Atlas of the Greater Twin City Metropolitan Area.** Includes 186 municipalities, 129 sectional street maps, and 22,000 street listings. Code #12-62, \$10.95.

**Minnesota Travel and Recreation Guide.** Where to go and what to see, canoeing and hiking trails, golf directory, campground directory, "Minne-Tours," state parks, hunting and fishing information and more. 296 pp., code #40-6, \$11.95.

**Room at the Inn: Guide to Historic Bed and Breakfasts, Hotels and Country Inns Close to the Twin Cities,** by Laura Zahn. 127 pp., Code #19-72, \$7.95.



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## Subscription Services

The Minnesota Documents Division offers several subscription services of activities, awards, decisions and special bulletins of various Minnesota state agencies.

Use the handy order form on the back of the *State Register* to order. Simply fill in the subscription code number, include your name, address and zip and your check made out to the State of Minnesota (PREPAYMENT IS REQUIRED) and send it in. We'll start your subscription as soon as we receive your order, or whenever you like.

SUBSCRIPTION	COST	CODE NO.	SUBSCRIPTION	COST	CODE NO.
Career Opportunity Bulletin, 1 year	\$ 20.00	90-3	State Register, 1 year	\$130.00	90-1
Career Opportunity Bulletin, 6 mos.	\$ 15.00	90-4	State Register, 3 mos. trial can be converted to a full subscription for \$90 at end of trial	\$ 40.00	90-2
Human Services Informational and Instructional Bulletin	\$100.00	90-6	Tax Court/Property Decisions	\$210.00	90-11
Human Services Bulletin List	\$ 20.00	90-7	Workers Compensation Decisions, unpublished subs run Jan-Dec; can be prorated	\$320.00	90-12
LRL (Legislative Reference Library) Checklist	\$ 75.00	90-8	Workers Compensation Decisions Vol. 38 (limited quantity)	\$ 89.50	
PERB (Public Employee Relations Board) Awards	\$260.00	90-9	Workers Compensation Decisions Vol. 39	\$ 95.00	90-13
PERB (Public Employee Relations Board) Decisions	\$ 60.00	90-10			
Minnesota Statutes Subscription Includes the complete 10-volume set of Minnesota Statutes 1986 and the 1987 Supplement	\$135.00	18-8			

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# Selling business and financial services to physicians?

## Physicians Directory 1985

Names and addresses of licensed chiropractors, doctors of medicine, and osteopaths, optometrists, podiatrists and registered physical therapists in alphabetical order by discipline. Includes members of all the state medical profession boards. Code #1-1, \$15.00.

## Medical Alley Directory 1986

A guide to more than 300 high-tech medical, bio-tech and health care companies, institutions and organizations and their products and services. Code #40-7, \$49.95.

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# For Real Estate Professionals:

## REAL ESTATE RULES 1986

Chapters 2800, 2805, and 2810 from the Minnesota Rules. *Essential* for both students and established brokers and salespersons. It contains all education and licensing requirements. Code No. 3-99. \$7.00.

## REAL ESTATE LAWS 1986

Includes all the changes made by the 1986 State Legislature. Complete and up-to-date. Code No. 2-92. \$5.00.

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## More: Minnesota's mushroom

*ROON: A Tribute to Morel Mushrooms*, this delightful treatise on the "filet mignon" of mushrooms will help the stalker of this elusive prey find, and prepare in a variety of ways, its mouth-watering madness. Code #19-55, \$9.50.

*Edible Mushrooms*, a classic guide to safe mushrooms, describes 60 species in detail, with photographs (many in color) to show each in its natural habitat. Advice to amateur mushroom hunters. Paperbound, 118 pp. Code #19-11, \$8.95.

*Mushrooms of North America*, full color poster, 24" x 37", showing 40 common species of edible and poisonous mushrooms. Code #15-13, \$8.50.

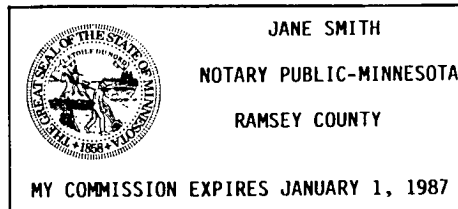
*Northland Wildflowers*, the perfect mushroomers companion. An excellent guide for identification and enjoyment of wildflowers, with 308 color photographs and descriptions of 300 species. Hardbound, 236 pp. Code #19-9, \$12.95.

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# 1986 NOTARY PUBLIC LAWS

Statutory requirements regarding the oath of office, necessary bond, and taking of depositions. Includes an explanation of the term of office and procedures for removal from office. Code No. 2-13. \$4.00.



## U.S. SMALL BUSINESS ADMINISTRATION PUBLICATIONS:

Insurance and Risk Management for Small Business	Code No. 16-50. \$3.00.
Small Business Finance	Code No. 16-42. \$4.50.
Starting and Managing a Small Business of Your Own	Code No. 16-40. \$4.75.

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## Catching criminals is only one part of law enforcement. Here's the rest of it.

**Police Report Writing Style Manual 1986**—A common framework for report writing throughout the state. Discusses the general purpose of police reports, reviews field notetaking, offers instructions on completing common report forms, and introduces the Data Practices Law. Code No. 14-13. \$12.50.

**Background Investigation Manual 1986**—A guide to conducting effective thorough background investigations of peace officer candidates. Included are various criteria for use in the selection process: experience, education, and past behavior. Sample forms. Code No. 14-15. \$10.00.

**Motor Vehicle Traffic Laws 1986**—Includes laws governing motor carriers, motor vehicle registration and no-fault auto insurance. Code No. 2-85. \$12.50.

**Criminal Code & Selected Statutes 1986**—Governs the conduct of peace officers. Includes continuing education requirements, sentencing standards, and more. Code No. 2-68. \$12.00.

**Blue Binder**—3 ring, 2" capacity. Criminal Code and Motor Vehicle Traffic Laws require 1 binder each. Code No. 10-21. \$4.25.



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## Murder: Minnesota style

**Murder in Minnesota** is a treasury of vintage crimes. Characters, some famous, some obscure, come to life in all their cleverness or murderous madness. Minnesota cases from 1858-1917. 253 pp, photos, index. Code 17-35, \$5.95.

**Robber and Hero** On September 7, 1876 six members of the James-Younger gang blasted their way out of Northfield, Minnesota. George Huntington's classic account of the Northfield Bank raid is as fascinating today as it was when first published 19 years after the attempted robbery. 125 pp., charts, maps, photos, with index. Code 17-40, \$5.95.

**Secrets of the Congdon Mansion** The prosecutor called it a crime of greed. A complex, intriguing murder case, set in one of Minnesota's most spectacular mansions, and now a top Minnesota tourist attraction on Duluth's famous Lake Superior North Shore Drive. By Joe Kimball, 64 pp., drawings. Code 19-56, \$4.95.

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# NEW Human Services Laws and Rules

## Human Services Laws 1986

An extract from the statutes. Includes legislative amendments and additions from the most recent session. Code No. 2-56. \$20.00

## Human Services Rules as in effect July 7, 1986

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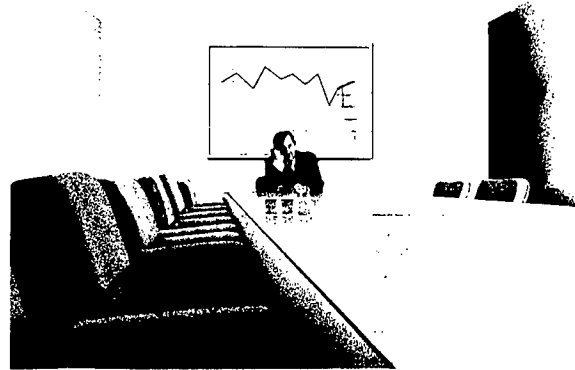
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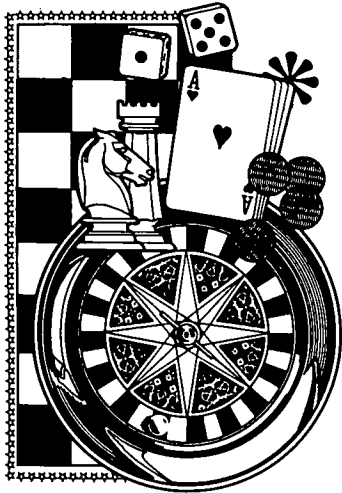
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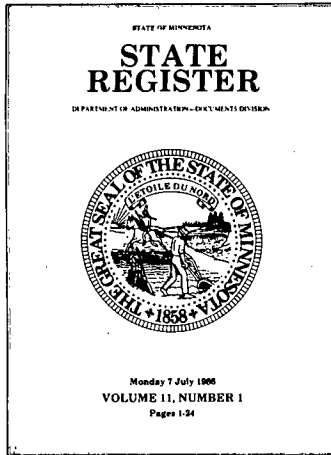
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