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State Register

STATE OF MINNESOTA

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MCAR AMENDMENTS AND ADDITIONS

List of amendments and additions to rules contained in the Minnesota Code of Agency Rules (MCAR) as published in the State Register, Volume 2:

RULES

Department of Public Welfare

Rules Governing the Medical Assistance Program

New DPW 47 repeals and supersedes old DPW 47.

DPW 47 Medical Assistance.

A. Introduction.

1. This rule governs administration of the Medical Assistance (MA) program in Minnesota. The provisions of this rule are to be read in conjunction with Title XIX of the federal Social Security Act, Title 45 of the Code of Federal Regulations, Minn. Stat. ch. 256B, and other rules of the Minnesota Department of Public Welfare (hereinafter, DPW or the state agency) which is responsible for the administration of the Title XIX program in Minnesota.

2. The MA program shall be administered to provide eligible needy persons whose financial resources are not adequate to meet the cost of medical care and services with such care and services, according to the provisions of this rule.

3. The MA program shall not be administered to deny applicants and recipients their individual and civil rights, nor to disclose information regarding them except as provided under applicable state law and/or official departmental rules and regulations.

4. This rule is binding on all county welfare boards (hereinafter referred to as local welfare agencies) in the State of Minnesota administering the MA program (Title XIX), on all providers of service participating in the MA program, on all applicants/recipients under the MA program, and on the state agency.

5. The official State Plan is the submitted and approved federal document which indicates those options covered by Minnesota Statutes.

7. This rule specifically includes by reference any federal laws or regulations or state laws pertaining to the Minnesota Medical Assistance program, and any provision of this rule which is inconsistent with those laws and regulations is superseded thereby.

B. Application for medical assistance.

1. Definitions.

a. "Applicant". A person who has directly, or through his authorized representative (or where incompetent or incapacitated, through someone acting responsibly for him), made application for Medical Assistance with his local welfare agency.

b. "Application". The action by which an individual indicates in writing to the agency administering public assistance his desire to receive Medical Assistance. An application is distinguished from an "inquiry", which is simply a request for information about eligibility requirements for Medical Assistance.

2. Any person has the right to apply for Medical Assistance to the local welfare agency in the county in which he resides and has established an abode, regardless of whether or not it appears he will be found eligible for participation in the MA program. In such cases, the local agency shall promptly advise the applicant of the MA program's eligibility requirements.

3. Each application form shall be signed by the applicant or the applicant's responsible relative, legal guardian or authorized representative (or where incompetent or incapacitated, by someone acting responsibly for him).

4. As soon as possible, but no later than 45 days from the date of application for Medical Assistance in the case of families, the aged and the blind, or no later than 60 days in the case of the disabled, the local welfare agency shall conduct a personal interview with the applicant and determine his eligibility for Medical Assistance. All eligibility conditions shall be met within these time limits. Where a delay is necessary because necessary information cannot be obtained within the time limits, the applicant shall be notified in writing of the delay and shall be advised of his right to appeal such delay.

5. Each applicant shall be notified in writing that his application has been approved or denied, unless the applicant dies or cannot be located. If the application is denied, the individual shall be notified in writing of the reasons for denial and of his right to appeal.

6. Any person has the right to re-apply for Medical Assistance. New applications must be taken whenever a

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previous application has been denied or withdrawn, or when the county of financial responsibility has been changed. An approved application shall be appended by an addendum thereto for the purpose of adding additional eligible persons or when the payee has changed his/her name.

7. Medical Assistance eligibility shall be redetermined in accordance with the provisions of applicable federal regulations. In those cases where the local welfare agency receives information about a change in case facts, eligibility shall be reviewed within 30 days of receipt of that information.

8. The local welfare agency shall verify information cited in this section and contained in the application received from the applicant or other persons or agencies only with the applicant's written permission. If the applicant refuses to cooperate with the local welfare agency in verifying the needed information, his application shall be automatically denied. The following information shall be verified:

a. Social Security numbers (as provided under (9) below) of all individuals applying for or receiving Medical Assistance and the parents of dependent children.

b. The applicant's income and property holdings.

c. Any other information affecting eligibility as deemed necessary under the circumstances of each particular case.

9. For assistance under Title XIX of the Social Security Act, the local welfare agency shall request each applicant to supply the Social Security number (SSN) for each individual (including children) for whom assistance is requested. Furnishing or applying for a SSN is not an eligibility factor for Medical Assistance and benefits cannot be denied because an individual will not furnish or apply for a SSN or consent to use of a SSN.

a. The local, state and federal agencies are prohibited from using an individual's SSN without the written consent of the individual, unless required by law to use that number.

b. The local welfare agency shall request in writing and obtain written consent to use the individual's SSN to validate information contained in the application.

10. Local welfare agencies shall give a copy of the state agency's informational pamphlet on Medical Assistance to every person who inquires about, indicates a need for, and/or applies for any of the categorical aid programs. Local welfare agencies shall inform all applicants that their medical records may, only with their signed consent, be released to the state agency, the local welfare agency, the Minnesota Department of Health, the U.S. Department of Health, Education and Welfare, and the PSRO. No records will be released to any person or agency absent the specific consent of the recipient. No person shall be eligible for medical assistance unless he has authorized in writing the Commissioner of Public Welfare to examine all personal medical records developed while receiving medical assistance for the sole purpose of investigating whether or not a vendor has submitted a claim for reimbursement, cost report or rate application which the vendor knows to be false in whole or in part.

11. Individuals found eligible for Aid to Families with Dependent Children (AFDC) shall be eligible for Medical Assistance without a separate application. Aged, blind or disabled individuals found eligible for Minnesota Supplemental Aid (MSA) shall be eligible for Medical Assistance without a separate application. Aged, blind or disabled Supplemental Security Income (SSI) recipients are required to file a separate application for Medical Assistance. Cases converted from state administered payments under OAA, AB and AD programs which are terminated by SSI require a separate application and determination of eligibility. All other individuals not specified herein shall file a separate Medical Assistance application.

12. Medical Assistance eligibility for a recipient of categorical assistance ends when there is no longer eligibility for that assistance. At that point, the individual shall file a separate Medical Assistance application and the MA program eligibility criteria must be applied.

13. The county in which the applicant resides at the time of application for Medical Assistance is the county of financial responsibility. Continuous receipt of assistance will continue financial responsibility in that county.

C. Eligibility factors under the medical assistance program.

1. Age.

a. Individuals eligible for Medical Assistance by reason of receiving a categorical form of public assistance, or who would be eligible under a category except for residence or amounts of income or resources, must meet the specific age requirements of the appropriate category.

b. Medical Assistance is available on behalf of

otherwise eligible individuals who were, for any portion of the month in which they received medical care or services, under 21 years of age (or under 22 years of age and receiving inpatient psychiatric hospital services), or 65 years of age or older.

c. The unborn are eligible for Medical Assistance during the last three months of the mother's pregnancy (as medically certified), so long as other factors of AFDC eligibility exist.

2. Residence.

a. "Residence" or "abode". Where a person lives and intends to remain.

b. Minnesota residence is an eligibility requirement for Medical Assistance but no specific length of residence is required. A person loses Minnesota residence when he leaves the state with the intent to establish a home elsewhere. Evidence of intent under this rule is not simply the person's stated intentions but includes consideration of objective criteria associated with the move (e.g., movement of possessions, rent payments, changes in voter or driver's license registrations).

c. A "resident" of Minnesota is a person who is living in the state voluntarily with the intention of making Minnesota his permanent home. A child is a resident of Minnesota if he is living in the state on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether he is there voluntarily or for a temporary purpose. An agricultural migrant who meets all other eligibility requirements and who has an abode in another state shall be eligible for Medical Assistance. Residence is deemed retained until abandoned. Temporary absence from Minnesota, with subsequent return to the state or intent to return when the purpose of the absence has been accomplished, does not interrupt continuity of residence.

d. Under the following circumstances, Medical Assistance will be furnished to eligible individuals who are residents of Minnesota but who are absent from the state, to the same extent that such assistance is furnished under the MA program to meet the cost of medical care and services rendered to eligible individuals within the state:

(1) Where an emergency arises from accident or illness;

(2) Where the health of the individual would be endangered if the care and services are postponed until he returns to Minnesota;

(3) Where his health would be endangered if he attempted to return to Minnesota in order to receive medical care.

e. Medical care and services will be provided outside Minnesota to eligible residents of this state in the following situations:

(1) When it is general practice for residents of Minnesota to use medical resources beyond the borders of this state; or

(2) When the availability of necessary medical care, services or supplementary resources make it desirable for the individual to use medical facilities outside the state, for short or long periods of time and in accordance with plans developed jointly by the local welfare agency and the individual, based upon sound medical advice.

f. The state agency shall assist in meeting the medical needs of residents of other states who are eligible for Medical Assistance in that state while they are within Minnesota.

3. Citizenship and alienage.

a. Medical Assistance payments may be made on behalf of any otherwise eligible individual who is a resident of the United States, but only if he is either:

(1) A citizen of the United States; or

(2) An alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

4. Income and resources.

a. Income.

(1) Medical Assistance may be paid for any person who anticipates receiving annual net income up to the amounts specified under state law. Individuals or families within income in excess of these maxima and who in the month of application or during the three preceding months incur expenses for medical care that total more than one-half of the annual excess income,

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may also be eligible for participation in the MA program.

(2) In the determination of eligibility for MA-only (over 65 years of age), and MA-categorically related, "income" is the total net income the applicant and relatives responsible under statutes expect to receive from all sources during the year.

(3) In determining eligibility for Medical Assistance for children under 18 years of age, the local welfare agency must consider all income of the applicants, and their relatives responsible under Minn. Stat. §§ 256B.06 and 256B.14. Eligibility of individuals between 18 and 21 years of age shall be determined separately.

(4) Definitions.

(a) "Income". Any benefit received by or available to a Medical Assistance applicant/recipient as earnings or otherwise. Income may be earned or unearned. In family groups living together, the income of a spouse is considered available to his/her spouse and the income of a parent is considered available to his/her children under 18 years of age. All income, including non-cash items provided free of cost, is considered a resource to be evaluated in determining the need of Medical Assistance applicants/recipients.

(b) "Net income". The amount left after deducting allowable expenses and income disregards.

(c) "Earned income". Income received in the form of wages, salary, commissions or profits from activities in which the applicant/recipient is engaged as an employee or as a self-employed person.

(d) "Unearned income". Income which is not the direct result of labor or services performed by the individual as an employee or as a self-employed person.

(5) The following employment expenses are to be deducted in determining net earned income:

(a) Mandatory retirement fund deductions.

(b) Transportation costs to and from work based on the actual cost of public transportation or carpool payments, or 13¢ per mile for the actual number of miles driven, not to exceed 100 miles per day of employment (unless the recipient can establish actual higher transportation costs).

(c) Cost of work uniforms.

(d) FICA and SMI payments.

(e) Federal and state income taxes withheld.

(f) Union dues.

(g) Professional association dues required for employment.

(h) Health insurance premiums.

(i) Cost of tools and equipment used on the job.

(j) One dollar per day for the cost of meals eaten during employment hours (unless the recipient can establish actual higher work-related meal expenses that are necessary and reasonable).

(k) Public liability insurance required by the employer when an automobile is used in employment and the cost is not compensated by the employer.

(6) Rental income is considered unearned income.

(7) Lump sum payments and windfalls (e.g., Social Security retroactive benefits, inheritances, income tax refunds, gifts) are considered a resource which will necessitate a redetermination of Medical Assistance eligibility, except when specifically exempted by federal law.

(8) Income of a Medical Assistance recipient, as in any other public assistance program, shall first be applied to the maintenance needs of the recipient or his legal dependents up to the statutory standards.

(9) Income that is within the legal maxima of the MA program is not to be considered in determining the amount of payments made for medical services, except in long term care facility, convalescent care unit, state veterans' facility and state hospital cases. In such cases, if the applicant/recipient has legal dependents (spouse and/or minor dependent children), the family's total net income, within the Medical Assistance legal maxima, is to be applied to the maintenance needs of the patient and those legal dependents. In such a situation the only income to be considered allocable to the maintenance needs of the long term care facility patient is the allowance for personal needs and clothing. Retarded or handicapped persons living in skilled nursing facilities, intermediate care facilities, or intermediate care facilities/mentally retarded who are employed under a plan of rehabilitation are eligible for a special personal allowance from earned income as specified in state statutes. The remainder of the income within the

legal maxima for the family is to be attributed to the maintenance needs of the legal dependents with any income over the Medical Assistance maxima to be applied to the institutional charges. If the patient has no legal dependents, any income in excess of the allowance for his personal needs and clothing is to be applied to the costs of long term care facility services.

(10) Income from an SSI grant is to be disregarded in determining the Medical Assistance eligibility of an SSI recipient. However, to be eligible under the MA program, other sources of income must comply with MA program standards.

(11) Persons receiving a maintenance grant under the AFDC or MSA programs shall be automatically eligible for Medical Assistance.

(12) Persons who have income in excess of the Medical Assistance income maxima and who do not qualify for categorical assistance because their income is in excess of the limits of those programs, may qualify for Medical Assistance through the spend-down provision of the MA program:

(a) "Spend-down" means to reduce available or anticipated income which exceeds the amount protected by state law for maintenance needs. Such reduction must be for current medical obligations.

(i) "Current" means medical obligations during the period of time the applicant is requesting assistance and which are allowable under state and federal law, or federal regulations.

(ii) "Medical obligations" are amounts owed any eligible provider for medical care, services or supplies which are covered under the MA program.

(b) Spend-down applies only to income.

(c) Spend-down is computed by the local welfare agency and is a condition of eligibility.

(i) Spend-down is computed by first determining the current and anticipated annual income of the applicant and his responsible relatives under state law.

(ii) The amount protected under state law is subtracted to determine the amount of anticipated annual income available to meet medical obligations.

(iii) This amount is reduced by one-half to indicate the anticipated income available during the next six (6) months.

(d) The spend-down requirement cannot be assumed by any third-party; such third-party resource shall be applied against medical obligations prior to determining the applicant/recipient's unmet medical obligation.

(i) For the purpose of spend-down only, "third-party" means anyone other than the applicant/recipient or his responsible relatives.

(e) The amount of spend-down shall be paid or incurred prior to establishing eligibility for Medical Assistance, except in those instances where a continuing spend-down exists.

(i) "Continuing spend-down" means the spend-down requirement is met on a monthly basis rather than on a six-month basis.

(aa) Continuing spend-down is limited to institutionalized individuals and those special situations individually approved by the state agency.

(f) When Medical Assistance eligibility is established through the spend-down provision, eligibility shall be limited to a period of six months beginning with the first of the month in which medical obligations are first incurred. This six month period may include retroactive coverage of up to three months prior to the first of the month in which the application was made.

b. Resources.

(1) Real property. Medical Assistance may be available to any individual who, either alone or together with his/her spouse, does not have equity in real property exceeding that permitted under state law. "Equity" shall be the assessed tax value minus any encumbrance against the property.

(a) In situations where the appropriate local welfare board determines that an applicant/recipient's excess equity in real estate cannot be converted into cash to meet his current maintenance needs, or that liquidation of the property would result in an undue hardship, the board may waive the equity limitation.

(i) It is not intended that this waiver pro-

vision be applied universally to achieve Medical Assistance eligibility for applicants or recipients. Instead, the following considerations shall act to restrict waiver of the real property equity limitation:

(aa) No maximum limit on the value of equity in real property to be waived shall be adopted by a local welfare board or local welfare agency as a matter of practice or general policy.

(bb) The circumstances and conditions under which the excess equity in real property was waived shall be examined periodically (at least annually) for changes in current market value, opportunity for sale or mortgage, or other pertinent factors.

(2) Personal property. Medical Assistance may be available to any individual whose cash or liquid assets do not exceed the limits established by state law.

(a) Under the MA program, the following items are exempted in determining the value of personal property owned by the applicant/recipient:

(i) Household goods and furniture presently used in the applicant's/recipient's residence.

(ii) Wearing apparel.

(iii) Life insurance policies with combined cash surrender values not exceeding $1,000 per insured person (individual applicant and each legal dependent or legally responsible member of his family).

(iv) Burial plots.

(v) Prepaid burial contracts not exceeding $750 for the applicant/recipient and each legally dependent member of his family, plus $200 in accrued interest under each such contract. In order to be covered by this exemption, either the funeral director must be the "trustee" and the applicant/recipient (or a member of his family for whom he is legally responsible) the "beneficiary" under the terms of such burial contract, or a trust account must be created restricting use of its funds to payment of funeral and burial costs.

(b) Equity in personal property exceeding the applicable program maxima may be waived when the appropriate local welfare board determines that liquidation of the property would result in undue hardship.

(c) If personal property increases in value beyond the limits allowed under applicable state law, it will not defeat Medical Assistance eligibility if the applicant/recipient, within 15 calendar days from the date he received notice from the local welfare agency, either:

(i) Transfers the excess to an excluded type of property; or

(ii) Uses the excess to repay the local welfare agency and/or state agency for Medical Assistance already received.

(d) A trust fund is subject to the personal property limitations mandated under applicable state law unless it can be affirmatively demonstrated that such fund cannot be made available to meet the individual's medical needs.

(3) At the time of filing application for Medical Assistance, each applicant shall submit a complete and accurate list and description of all real and non-exempt personal property in which he has an equitable interest. Such list of property shall include not only the property currently owned, but all property in which he had an equitable interest during the three years prior to applying for Medical Assistance.

(4) Transfers of property. The establishment of initial or continuing eligibility for Medical Assistance by disposing of resources which otherwise would be available for the applicant/recipient's support is contrary to public policy. In some instances, such dispositions may constitute a criminal offense on the part of the donor and/or donee of the property. If a person tenders any amount of money as a deposit to a long term care facility within three years immediately preceding his application for Medical Assistance, or while receiving such assistance, all such deposits shall be considered a resource in determining such person's eligibility for Medical Assistance.

(a) The following provisions shall govern property transfers as they affect potential eligibility under the MA program:

(i) Each applicant for and recipient of Medical Assistance shall be required to reveal whether he has transferred within the preceding three years real or personal property with a total fair market value in excess of $750 without receiving adequate consideration for such property. Any property so transferred shall be viewed as an available resource for the medical needs of the applicant/recipient.

(ii) The applicant or recipient who has transferred property as described in this section shall be required to provide to the local welfare agency a description, including value, of the property transferred; the name or names of all persons who received such prop-

erty; and the specific circumstances under which the property was transferred.

(iii) The applicant or recipient who has transferred property as described herein shall be required to make a reasonable effort in cooperation with the local welfare agency to reacquire the property transferred.

(iv) The information required by (ii) and the efforts made to reacquire the property mandated by (iii), shall be entered in the applicant/recipient's case record with the appropriate eligibility determination.

(v) If return of the property or adequate consideration for the property cannot be arranged by the local welfare agency, the matter of the property transfer shall be reported with full documentation to the county attorney for possible criminal prosecution or civil action.

(vi) Transfer of property in violation of this rule shall not, in itself, constitute automatic ineligibility for Medical Assistance since such property may be deemed, in fact, to be unavailable to meet the applicant/recipient's medical needs.

(5) Types of property ownership. The owner of property in joint tenancy shall be considered as owning his pro-rata share of the value of such property, but the county or the joint tenant may establish ownership of a greater or lesser amount. An owner of property as a tenant-in-common owns his pro-rata share of the property's value. All other types of ownership shall be evaluated according to the law.

(6) Assignment of benefits. Each applicant or recipient shall as a condition of eligibility:

(a) Notify his county of service of any health care coverage available to him or his dependents and agree to apply all proceeds received or potentially receivable by him or his spouse from private health care coverage to the costs of medical care for himself, his spouse and children; and

(b) Assign any rights accruing under private health care coverage to the state agency, to be applied against the cost of medical care paid for by the MA program.

5. Relative responsibility. Within the limitations provided by state law and this rule, the spouse of an applicant or the parent of an applicant under 18 years of age shall be charged with the cost of medical services before Medical Assistance shall be available. The local welfare agency shall not withhold, delay or deny Medical Assistance because a responsible relative deemed able to contribute fails or refuses to accept financial responsibility. When the local welfare agency determines that a responsible relative is able to contribute without undue hardship to himself or his immediate family but refuses to contribute, the local welfare agency shall exhaust all available administrative procedures to obtain that relative's contribution. When such procedures fail, the local welfare agency shall consult its county attorney regarding possible legal action.

a. The local welfare agency shall assess the income and resources of an applicant, together with that of his/her spouse, in determining eligibility for Medical Assistance, subject to the following limitations:

(1) If spouses are living separately, the local welfare agency may determine that the marital relationship has experienced a breakdown likely to make spousal support impractical.

(a) Where there is joint ownership of either real or personal property in excess of statutory allowances, the local welfare agency cannot conclude that a total breakdown of the marital relationship has taken place.

(2) If the responsible relative fails to contribute support, after the local welfare agency notifies him of his obligation to do so, the local welfare agency shall notify the county attorney in an effort to commence legal action against that relative.

(3) The amount of support recoverable from a responsible relative (other than an absent parent) shall not exceed the amount of assistance paid on behalf of the recipient.

6. Marriage or remarriage of parent. In the event that a parent with dependent children under 18 years of age marries or remarries and applies for Medical Assistance on behalf of those dependent minor children residing with him or her, the following provisions shall apply in determining available income with relation to eligibility for Medical Assistance:

a. All income and resources of natural or adop-

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tive parents who reside in the home are to be considered available to meet the medical needs of the children.

b. All income and resources of the children themselves must be considered available to meet the medical needs of the children so long as such income and resources are under the control of the parents.

c. All other income and resources available to the MA applicants/recipients received in the form of gifts, income-in-kind, support payments, whether from responsible relatives or other family members, must be considered as a resource available to the children in determining their eligibility for Medical Assistance.

d. All income-in-kind received by the natural or adoptive parent must also be considered as an income or resource in determining Medical Assistance eligibility for the children.

e. Proof of actual contribution by relatives or other persons may be obtained by reference to previous income tax returns on which these children may have been declared as dependent by the parent or adult family member. Such proof of support or contribution may also be obtained by direct inquiry of the adult family members residing in the home.

7. Institutional status. An individual who is an inmate of a public institution, except as a patient in a medical institution or as a resident of an intermediate care facility, is not eligible for Medical Assistance. Individuals over age 65 and under age 21 who are patients in institutions for mental diseases or tuberculosis are eligible for Medical Assistance if all conditions of eligibility are satisfied.

a. Definitions.

(1) "Inmate". A person who is being involuntarily retained and who is living in the institution.

(2) "Public institution". A facility that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

(3) "Patient". An individual who is in need of and receiving professional services directed by a licensed practitioner of the healing arts towards the maintenance, improvement or protection of health, or the alleviation of illness, disability or pain.

(4) "Resident". An individual receiving room, board and a planned program of care and supervision on a continuous 24-hour-a-day basis as determined necessary by a licensed physician or, if appropriate, a mental retardation team.

(5) "Institution". An establishment which furnishes (in single or multiple facilities) food and shelter to four or more individuals unrelated to the proprietor and, in addition, provides treatment serives which meet some needs of the individuals beyond the basic provision of food and shelter.

8. Termination of medical assistance.

a. Medical Assistance applicants and recipients have the right to a fair hearing when aggrieved by action or inaction of the local and/or state welfare agencies. Such hearings shall be conducted in accordance with contested case and/or appeal procedures established by and consistent with applicable state law and federal regulations. The aggrieved applicant/recipient shall submit a written request for a hearing to the state or local welfare agency, whichever is appropriate. A local welfare referee shall conduct a hearing on the matter and shall issue a ruling affirming, reversing or modifying the action or decision of the local agency. The ruling of the local welfare referee shall be binding upon the local agency and the aggrieved party unless appeal is taken to the state agency. If appeal is taken directly to the state agency, a state welfare referee shall conduct a hearing on the matter and shall recommend an order to the Commissioner of Public Welfare. In appeals to the state agency from rulings of local welfare referees, the hearing may be limited, upon stipulation of the parties, to a review of the record of the local welfare referee. The Commissioner of Public Welfare shall issue an order on the matter to the local agency and the applicant/recipient. Any order so issued shall be conclusive upon the parties unless appeal is taken to District Court. Termination of Medical Assistance may be effected only at the end of the month, except in the case of the death of the recipient.

(1) An applicant/recipient for Medical Assistance is entitled to a hearing when the local welfare agency fails to act on his application within the time limits imposed by applicable federal regulations, or when his Medical Assistance coverage is to be denied or terminated (See, B.4, *supra*).

(2) The local welfare agency board shall give the applicant/recipient timely advance notice of its intention to deny or terminate Medical Assistance. This notice shall be in writing and mailed to the applicant/recipient at least 10 calendar days prior to the effective date of such proposed action and shall clearly state what action the local welfare agency intends to take, the reasons for such proposed action and the right to appeal such proposed action.

(3) If the applicant/recipient appeals the proposed action before it is effected, the action shall not be

taken until the appeal is heard and decided in accordance with applicable state law and federal regulations.

D. General administration.

1. Free choice of provider. Subject to the following limitations, the MA program shall provide eligible recipients with free choice of participating local medical providers. The term "local" as used herein means that geographic area surrounding the recipient's residence which is viewed by the local welfare agency as reasonable for obtaining any given medical service.

a. Free choice is limited by the choice available to the local population.

b. Eligible recipients may exercise free choice by enrolling in participating Health Maintenance Organizations (HMO). While enrolled in an HMO, the recipient is limited to free choice within that HMO.

c. No long term care facility shall be eligible to receive medical assistance payments unless it agrees in writing that it will refrain from requiring any resident of the facility to utilize a vendor of health care services who is a licensed physician or pharmacist chosen by the facility.

2. County medical assistance plan. Counties shall administer the MA program according to the rules, procedural regulations and policies of the state agency, Minnesota Department of Public Welfare (DPW). Each local welfare agency shall develop methods and procedures for keeping adequate records to:

a. Verify current individual eligibility for the MA program.

b. Justify that payment for long term care facility services was correctly made.

c. Record individual eligibility for levels of care or other federal regulatory requirements as prescribed by the state agency.

3. The county of service (physical residence of eligible recipient) is responsible for submitting necessary information to DPW to insure compilation of an accurate recipient eligibility file. The county of service is solely and fully responsible for any payments made on behalf of ineligible recipients as a result of:

a. Late or inaccurate redeterminations of eligibility.

b. Non-compliance with utilization review and control requirements (See, D. 10, *infra*).

c. Inaccurate or incomplete record-keeping or failure to satisfy other written requirements (See, D.4.b, *infra*).

d. Failure to submit accurate information on recipient eligibility to DPW.

4. Records. The state and local welfare agencies and all medical providers shall maintain separate medical and/or fiscal records.

a. The state agency shall:

(1) Keep records necessary for a centralized disbursement system which maximizes federal financial participation (FFP);

(2) Maintain a recipient eligibility file based on information supplied by the county of service;

(3) Maintain records on all eligible providers; and

(4) Maintain an information retrieval system for necessary statistical reports and/or audits of payment.

b. Local welfare agencies shall:

(1) Maintain eligibility records to include at a minimum the recipient's application and redetermination forms, as necessary or advisable for efficient administration of the MA program; and

(2) Maintain records containing a physician's certification of the recipient's need for inpatient care to be used by DPW's utilization review and control system.

c. Medical providers participating in the MA program shall:

(1) Maintain for at least five (5) years, in the manner prescribed by DPW in accordance with applicable federal regulations, medical and financial records fully disclosing the extent of service provided, the medi-

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cal necessity for such service and payment claimed under the MA program;

(2) On request, and upon being provided a copy of the recipient's written consent, make their records available to DPW, the state Legislative Auditor and the Department of Health, Education and Welfare (or representatives of those agencies) in order to justify all payments made to such provider and the propriety of all services rendered by such provider under the MA program;

(3) Not be subject to any civil or criminal liability for providing access to medical records to the commissioner of public welfare pursuant to Minn. Stat. ch. 256B.

5. Third-Party liability. The term "third-party" as used herein includes, but is not limited to, insurance companies, (including HMOs); other governmental programs such as Medicare; Worker's Compensation; and potential defendants in legal actions arising out of any type of accident or intentional tort. Insurance companies are liable for full payment of policy benefits on behalf of beneficiaries and any overage will be forwarded to the provider of service. Any recovery through court action shall be considered as a resource to the recipient in determining eligibility for Medical Assistance. A trust fund is a resource of first recourse.

a. The local welfare agency shall:

(1) Determine and identify any third-party which has a potential legal liability to pay for medical care provided eligible Medical Assistance recipients prior to establishing or continuing recipient eligibility; and

(2) As provided under state law, file its verified lien statements within one year from the date the last item of medical care was furnished.

b. The state agency shall:

(1) Seek recovery of all third-party liability benefits;

(2) Distinguish between third-party liability which is a current resource and one which is not current, based on the following considerations:

(a) Current liability consists of but is not limited to, known amounts of participation or coverage payable by liable third parties; the amount of actual claims, payments or settlements received.

(b) Liability which is not current includes potential resources such as legal actions or disputable claims whose results are speculative and uncertain. In such cases, the state agency shall either perfect a lien or refer the matter to the county attorney in the county of financial responsibility for the purpose of perfecting a lien.

(3) File its verified lien statement within one year from the date the last item of medical care was furnished; and

(4) Refrain from withholding payment on behalf of an otherwise eligible recipient when third party liability cannot be readily determined or collected.

6. Identification card. The state agency or the local welfare agency as directed by the state agency shall periodically issue Medical Assistance identification (ID) cards to eligible recipients, or if the recipient is legally incompetent to his guardian. Recipients shall show each provider a valid ID card establishing identity and current eligibility before obtaining medical care. Nothing in this rule shall be construed as requiring a provider to provide services to a recipient who fails to present a currently valid ID card. A provider may contact the local welfare agency for verification of current eligibility if the recipient fails to present a currently valid ID card. The state agency may restrict the use of ID cards to particular providers of specified services when necessary to prevent duplication or documented abuse of services, to prevent violation of prior-authorization requirements, or to assure continuity of care. Such restrictions on the use of ID cards shall be subject to the fair hearing requirements of applicable state law and federal regulations (See, C.8.a., *supra*). The state agency will periodically issue ID cards until instructed by the county of service that Medical Assistance eligibility no longer exists. The state agency shall automatically cease to issue cards when a spend-down period ends, when eligibility redeterminations are more than 90 days overdue, or when the special four month AFDC extended medical periods terminate in accordance with applicable federal regulations. Local welfare agencies shall notify the recipient during the first five days of the last month of eligibility prior to the automatic discontinuance to issue ID cards. The state agency shall be fully responsible for payments made on behalf of ineligible individuals due to state processing error.

7. Agreements with providers. An eligible provider is a vendor of medical care, services or supplies which meets federal and state standards for participation in the MA program, complies with all requirements of this rule, and executes a provider agreement. Providers shall complete and sign an appropriate provider agreement in the form stipulated by DPW. Failure by the provider to comply with federal and state statutes, rules and regula-

tions pertinent to the MA program shall result in termination of the provider agreement, ineligibility to receive MA program reimbursement and, where appropriate, action to recover Medical Assistance funds. In order to be eligible for reimbursement under the Minnesota MA program, out-of-state providers must complete and sign an appropriate provider agreement and comply with all licensing and certification requirements of the state or Canadian province in which they are located.

8. Qualification of eligible providers. The state agency shall determine the eligibility of each provider of medical care, services and supplies. Any medical vendor who, on request, and upon being provided a copy of the recipient's written consent, refuses to allow a proper survey and/or reimbursement agency access to its records, shall become an ineligible provider upon written notification from DPW. The Commissioner may terminate payments under Chapter 256B to any person or facility providing medical assistance which under applicable federal law or regulation, has been determined to be ineligible for payments under Title XIX of the Social Security Act. Any vendor of medical care who submits to the state agency a claim for reimbursement, a cost report, or a rate application which he knows to be false in whole or in part shall be declared ineligible for further payments of medical assistance funds by the commissioner of public welfare. The commissioner shall determine the time period of ineligibility and any conditions for reinstatement of eligibility. No vendor of medical care shall be declared ineligible without prior notice and an opportunity for a hearing, pursuant to Minn. Stat. ch. 15, on the commissioner's proposed action.

9. Prior authorization. Services and items of care which must receive prior authorization are so indicated in Sections E.2.a. thru E.2.s, *infra*. The state agency shall provide vendors of medical care with designated forms to be used in making prior authorization requests. The vendor shall submit the contemplated charge and sufficient information to allow a reasonable evaluation of the request. The state agency shall send a form to the provider indicating whether the requested authorization has been approved or denied. The state agency shall use the following criteria in evaluating prior authorization requests in order to:

a. Safeguard against the unnecessary or inappropriate utilization of care and services;

b. Safeguard against excess payments;

c. Assess the quality and timeliness of such services;

d. Determine if less expensive alternative medical care, services or supplies are usable;

e. Promote the most effective and appropriate use of available services and facilities; and

f. Attempt to rectify misutilization practices of providers, recipients and institutions.

Emergency services may be covered under the MA program even if the required prior authorization was not obtained. In order to be covered, the provider shall attach to the invoice an explanation of the circumstances under which the services were provided and why such services should be classified as emergency care. The state agency shall reimburse only those services usually requiring prior authorization for which emergency status is established.

The state agency may delegate the responsibility for prior authorization of specific items and services to the local welfare agency which shall be responsible for implementing the methods and procedures prescribed.

10. Utilization control.

a. A statewide surveillance and utilization control program is established subject to applicable federal law and regulations. Such program shall include:

(1) An ongoing evaluation of the necessity for and the quality and timeliness of the services provided to eligible individuals under the MA program in order to promote the most effective and appropriate use of available services and facilities.

(2) A post-payment review process which allows for the development and review of recipient utilization profiles, provider service profiles, exception criteria, and one which identifies exceptions in order to rectify misutilization practices of recipients, providers and institutions.

b. Utilization control of inpatient hospital services and services provided in skilled and intermediate care facilities. Under this surveillance and utilization control program, all inpatient facilities shall:

(1) Have in effect a written utilization review

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plan which meets the requirements of applicable state law and federal regulations;

(2) Provide that the committee performing the utilization review activities will review each eligible individual's discharge plan to be developed in accordance with applicable state law and federal regulations;

(3) Obtain physician certification prior to or at the time of admission that such inpatient services are medically necessary or, in the case of an individual who applies for Medical Assistance while in an institution, obtain physician certification prior to authorization of payment;

(4) Obtain physician recertification at least every 60 days thereafter that such services continue to be medically necessary;

(5) Develop written plans of care in accordance with applicable state law and federal regulations; and

(6) Cooperate in a quality assurance and review program established by the Minnesota Department of Health in cooperation with DPW and in accordance with the provisions of applicable state law and federal regulations.

c. In accordance with the surveillance and utilization control program, all long term care facilities (i.e., skilled nursing facilities, intermediate care facilities, mental hospitals) shall provide for:

(1) A periodic review and evaluation of the necessity for admission and continued stay of each eligible individual receiving inpatient long-term care facility services. Such review and evaluation shall be performed by medical and other appropriate professional staff who are not themselves directly responsible for the care of eligible individuals, nor financially interested in any such institution nor (except in the case of mental hospitals) employed by such institution. Such reviews and evaluations shall be carried out in accordance with the requirements specified in applicable federal regulations.

(2) Review by the state agency (or its designee) of the recommendations for admission, in accordance with applicable federal regulations.

d. Under the surveillance and utilization control program, the state agency shall:

(1) Establish and implement a program of medical review (including medical evaluation and on-site inspection) of the care provided patients in mental hospitals and skilled nursing facilities, and a program of independent professional review (including medical evaluation and on-site inspection) of the care provided residents in intermediate care facilities both of which shall satisfy the requirements of applicable federal regulations.

11. Transportation. The MA program shall pay for transportation through the centralized payment system only in accordance with section E.2.r.(1), *infra*. However, local welfare agencies may approve and pay for transportation when furnished by someone other than an enrolled medical provider. Such service must receive prior authorization and shall be reimbursable from the local welfare agency's medical assistance administrative account.

E. Services under the medical assistance program.

1. The following services are not covered under the MA program:

a. Medical services or supplies paid for directly by the recipient.

b. Medications dispensed by a physician that could reasonably be obtained from a licensed pharmacy (See, E.2.n., *infra*).

c. Medical services or supplies where the requisite prior authorization was not submitted or was denied.

d. Autopsies.

e. Missed appointments.

f. Telephone calls or other non face-to-face communication between the provider and the recipient.

g. Routine reports (e.g., Social Security, insurance) unless requested by the state agency.

h. Investigational surgery or procedures (e.g., research efforts not clearly essential to the patient's health).

i. Illegal operations and other procedures prohibited by law.

j. Artificial insemination.

k. Transsexual surgery.

l. Aversion therapy (including cash payments from recipients) unless provided in accordance with DPW 39.

m. Cosmetic surgery aimed at beautification only.

n. Weight reduction programs unless:

(1) The program treats a medical condition causing obesity; or

(2) Obesity interferes with the health, well-being or employability of the recipient.

o. Billing charges.

p. Mileage charged by eligible providers.

q. Reversal of voluntary sterilization procedures.

r. Medical care or services for an individual who is an inmate of a public institution, except as a patient in a medical institution or as a resident of an intermediate care facility (i.e., an individual who is under the care or control of a correctional authority).

s. Duplication of services by more than one provider without appropriate medical referrals.

2. The following services are covered under the MA program:

a. Inpatient hospital services. "Inpatient hospital services" are those items and services ordinarily furnished by a hospital for the care and treatment of inpatients; and which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases; and which is licensed or formally approved as a hospital by the Minnesota Department of Health; and which is qualified to participate under Title XVIII of the Social Security Act or is determined currently to meet the requirements for such participation; and which has in effect a utilization review plan applicable to all patients who receive Medical Assistance under Title XIX of the Social Security Act which meets applicable federal requirements, unless a waiver has been granted by the Secretary of the Department of Health, Education and Welfare. All inpatient hospitals certified for participation under Medicare (Title XVIII) are eligible to participate in the MA program upon completion of a provider agreement.

(1) The following inpatient hospitalization services must receive prior authorization:

(a) Medical care of marginal medical necessity.

(2) The following limitations apply to inpatient hospital services:

(a) Private room — must be certified by a licensed physician as medically necessary, unless the private room rate does not exceed the semi-private room rate in that hospital.

(b) The hospital must comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply with these requirements will result in denial of payment by DPW.

(3) The following inpatient hospital services are not covered under the MA program:

(a) Leave days, leaves-of-absence and reserved beds as defined under federal regulations.

b. Long term care facility services. "Long term care facility services" are those services provided in facilities (or distinct parts thereof) licensed by the Minnesota Department of Health and certified as eligible providers of skilled nursing facility services, intermediate care facility services, tuberculosis or mental hospital services, or those facilities similarly licensed in another state or a Canadian province. The term "long term care facilities" (LTC) as used herein includes skilled nursing facilities (SNF), intermediate care facilities (ICF), and tuberculosis or mental hospitals.

(1) "Skilled nursing facility services" (other than services in an institution for tuberculosis or mental disease) are those services provided in a SNF. A SNF is a facility:

(a) Certified by MDH as meeting the requirements of Title XVIII of the Social Security Act, except that the exclusion contained therein with respect to institutions which are primarily for the care of tuberculosis or mental disease shall not apply and

(b) Which meets the requirements of applicable federal regulations.

(2) "Intermediate care facility services" (other than services in an institution for tuberculosis or mental disease) are those services provided for individuals who are determined, in accordance with Title XIX of the Social Security Act, to be in need of the care provided in an ICF. An ICF is an institution which:

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(a) Is licensed under state law to provide on a regular basis health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide but who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities;

(b) Satisfies the standards prescribed by the Secretary of Health, Education and Welfare as necessary for the proper provision of such care as enumerated in applicable federal regulations; and

(c) Meets such standards of safety and sanitation as mandated by federal regulations.

The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements described above. With respect to services furnished to individuals under age 65, the term intermediate care facility does not include any public institution for mental diseases or mental defects except it may include services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

"Intermediate care facility services/nursing home" means services provided in an ICF-NH. An "ICF-NH" is an institution licensed as a nursing home and which meet each of the conditions described above. "Intermediate care facility services/boarding care home" means services provided in an ICF-BCH or which could be provided in an ICF-BCH. An "ICF-BCH" is an institution licensed at least as a boarding-care home and which meets each of the conditions described above.

"Intermediate care facility services/mentally retarded" means services provided in an ICF/MR. An "ICF/MR" is an institution licensed by the Minnesota Department of Health, licensed in accordance with DPW 34 and which meets each of the conditions described above.

"Intermediate care facility services/ chemically dependent" means services provided in an ICF/CD. An "ICF/CD" is a facility licensed by the Minnesota Department of Health, licensed under DPW 35 and which meets each of the conditions described above.

(3) "Inpatient psychiatric hospital services for individuals under age 21" are those services provided in an institution which is accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals. Such services include only inpatient services which, in the case of an individual:

(a) Involve active treatment which meets the standards prescribed by the Secretary of Health, Education and Welfare;

(b) Are provided by a team (consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and treatment thereof) and determined to be necessary on an inpatient basis and which can reasonably be expected to improve the condition giving rise to the need for such services, to the extent that eventually such services will no longer be necessary; and

(c) Are provided prior to the date such individual attains age 21, or if the individual was receiving such services during the period immediately preceding his twenty-first birthday, such services may be continued up to the date the individual no longer requires such services or the date the individual attains age 22, whichever date comes first.

(4) Inpatient hospital, SNF and ICF services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases.

(a) "Inpatient hospital services in an institution for mental diseases" are those items and services which are provided under the direction of a licensed physician for the care and treatment of inpatients in a psychiatric hospital which meets the requirements of Title XVIII of the Social Security Act.

(b) "Inpatient hospital services in an institution for tuberculosis" are those items and services which are provided under the direction of a licensed physician for the care and treatment of inpatients in a tuberculosis hospital which meets the requirements of Title XVIII of the Social Security Act.

(c) "Skilled nursing facility services" are those items and services furnished by a skilled nursing facility as defined by applicable federal regulations.

(d) "Intermediate care facility services" are those items and services furnished by an intermediate care facility, as defined by applicable federal regulations, to residents who have been determined in accordance with such federal regulations to be in need of such care.

(e) An "institution for mental diseases" means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases including medical attention, nursing care and related services.

(f) An "institution for tuberculosis" means

an institution which is primarily engaged in providing diagnosis, treatment or care of persons with tuberculosis including medical attention, nursing care and related services.

(5) Levels of care. Reserved for future use.

(6) General limitations.

(a) Payment will be made only to facilities that have in effect an approved utilization review plan and which meet all other requirements of the surveillance and utilization control program prescribed by applicable federal regulations.

(b) Medical Assistance is not available on behalf of any individual who is an inmate of a public institution (except where a patient is in a medical institution (See, Minn. Stat. § 256B) or is a resident of an intermediate care facility) or any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases. An individual on provisional discharge or convalescent leave from an institution for mental diseases is not considered to be a patient in such institution. An institution for the mentally retarded or an institution for the chemically dependent is not considered an institution for mental diseases.

(c) Payments to institutions for the mentally retarded or persons with related conditions shall not include reimbursement for vocational and educational activities.

(d) Payment will be made to facilities only in accordance with applicable federal reimbursement formula regulations.

(7) Health care facility report. Every facility required by state law to be licensed by the Minnesota Department of Health shall provide such annual reports to the Commissioner of Public Welfare as may hereafter be required. Each health care facility participating under the MA program shall provide the Commissioner of Public Welfare with a full and complete financial report of the facility's operations, including:

(a) An annual statement of income and expenditures;

(b) A complete statement of fees and charges;

(c) The names of all individuals, partnerships and corporations (other than mortgage companies) owning any interest of ten percent (10%) or more of the facility; and

(d) The names of all owners of interest in the facility as defined in (c), or the children, parents or spouses of such owners who own an interest in any other health care facility or organization doing business with the MA program or who are otherwise enrolled as providers.

A DPW 49 or DPW 52 cost report shall satisfy this requirement. The financial records, reports and supporting data of each participating facility shall be accessible for inspection and audit by the Commissioner of Public Welfare or designees.

c. Physician services. 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.

(1) The following physician services must receive prior authorization:

(a) All medical, surgical or behavioral modification services aimed specifically at weight reduction.

(b) 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.

(c) Removal of tattoo.

(d) Payment for physicians' services exceeding thirty (30) days of inpatient psychiatric treatment per calendar year.

(e) Individual hourly sessions with a psychiatrist licensed to practice medicine in the U.S. or Canada in excess of ten (10) per calendar year.

(2) The following are limitations to physicians' services:

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(a) The MA program will pay for up to 10 hourly sessions with a psychiatrist licensed to practice medicine in the U.S. or Canada per calendar year for any eligible recipient.

(b) The MA program will pay for up to 26 additional hourly sessions with a psychiatrist licensed to practice medicine in the U.S. or Canada per calendar year when all of the following conditions exist:

(i) Three or more members of one family unit are all seen together at every session; and

(ii) The 26 hourly sessions extend over a period of time greater than six consecutive months; and

(iii) At least one of the family members is under age 18.

(c) The MA program will pay for ongoing chemotherapy management on a once-a-week average basis, provided that both of the following conditions apply:

(i) The medication required is an anti-psychotic or anti-depressant; and

(ii) No more than 52 sessions take place within a twelve month period.

(d) The MA program will pay for family psychotherapy of two family members (conjoint psychotherapy with continuing medical diagnostic evaluation and drug management) as needed for up to two hours per week for a twenty week period. (When more than two family members are involved, See, E.2.c.(2)(b), *supra.*)

(e) The MA program will pay for multiple family group-psychotherapy or group-psychotherapy for up to two hours per week for a ten week period.

d. Health maintenance organizations (HMO). Health Maintenance Organizations are organizations licensed by the state which provide comprehensive health care to a voluntarily enrolled population in a specified geographic area. The MA program shall reimburse participating HMOs through a pre-negotiated and fixed per capita payment determined in accordance with applicable federal regulations made on behalf of nerolled recipients. HMOs shall provide, either directly or through arrangements with other medical providers, for all medical services and supplies covered under the official Medical Assistance State Plan. HMO services shall be provided in accordance with the HMO contract and shall not be subject to service limitations, prior authorization requirements and billing and recovery procedures under this rule.

e. 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.

(1) 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:

(a) 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.

(b) 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.

(c) Payment is limited to 6 treatments per month and 24 treatments per calendar year for each eligible recipient. Treatment in excess of these maxima must receive prior authorization.

(d) The MA program shall not cover x-rays nor any other diagnostic or laboratory procedure provided by a chiropractor.

(2) Podiatrists. The MA program limits payment for podiatry services as follows:

(a) 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.

(b) A limit of 3 visits per month and 12 visits per year is placed on the following:

(i) Total office and outpatient visits.

(ii) Total home or long term care facility visits.

(iii) Hospital visits.

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

(d) The following podiatry services are not covered under the MA program for long term care facility patients:

(i) Ordinary foot hygiene.

(ii) Use of skin creams to maintain skin tone.

(iii) Normal trimming of nails and other services that can reasonably and safely be performed by LTC facility personnel.

(3) 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 State 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.

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

(i) Contact lenses.

(aa) Supplemental contact lens evaluation.

(bb) Contact lens check-up.

(cc) Spherical lens fitting (single vision).

(dd) Cylindrical, lenticular, aphakic or prism ballast lenses.

(ee) Keratoconus lenses.

(ff) Cosmetic lenses (disfigurement only).

(gg) Fitting previous contact lens wearer.

(hh) Soft contact lens fitting.

(ii) Fitting monocular patient.

(ii) Custom-fit prosthetic eye.

(iii) Amblyopia therapy.

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

(iv) Strabismus therapy.

(aa) "Strabismus" includes all test procedures necessary for classification, degree of squint and determination of expecteds.

(v) Vision therapy-supplemental evaluation and report.

(vi) More than one (1) pair of eyeglasses in any single 12 month period.

(vii) Photochromatic lenses: Must be accompanied by a statement of medical necessity.

(viii) Sunglasses: Must be accompanied by statement of medical necessity.

(ix) Lens coating-surface or edge.

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

(i) Services provided principally for cosmetic reasons, including:

(aa) Contact lenses prescribed for reasons other than aphakia, keratoconus, aniseikonia or marked acuity improvement over spectacle correction.

(bb) Replacement of lenses or frames due to a recipient's personal preference for a change of style or color.

(ii) Technical services related to the provision of non-covered services.

(4) 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.

(a) The following psychological services must receive prior authorization:

(i) Services in excess of the limitation on the number of visits (See, below).

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

(i) The MA program will pay for up to 10 hourly sessions with a licensed psychologist per calendar year for any eligible recipient.

(ii) 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:

(aa) Three or more members of one family unit are all seen together at every session; and

(bb) The 26 hourly sessions extend over a period of time greater than six consecutive months; and

(cc) At least one of the family members is under age 18.

(iii) The MA program will pay for family psychotherapy of two family members as needed for up to two hours per week for a twenty week period. (When more than two family members are involved, See, E.2.e.(4)(b), *supra*.)

(iv) The MA program will pay for multiple family group-psychotherapy or group-psychotherapy for up to two hours per week for a ten week period.

(c) The following psychological services are not covered under the MA program:

(i) Medical supplies and equipment.

(5) 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:

(a) Health assessment and screening.

(b) Health promotion and preventive counseling.

(c) EPSDT screening if approved by the Minnesota Department of Health.

(d) 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.

f. Outpatient hospital services. "Outpatient hospital services" are preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished by or under the direction of a licensed physician or dentist to an outpatient in an outpatient facility which is licensed as a hospital by the state and which is qualified to participate under Title XVIII of the Social Security Act, or is currently determined to meet the requirements for such participation. All outpatient hospitals certified to participate under Medicare (Title XVIII) are eligible to participate in the MA program upon completion of a provider agreement.

(1) The following outpatient hospital services must receive prior authorization:

(a) Kidney dialysis not covered by Medicare.

(b) Oral surgery (except in emergencies).

(c) Hemodialysis back-up service.

(d) Supplemental and tube feedings for patients who have special nutritional needs.

(e) All physician services which must receive prior authorization (See, E.2.c.(1), *supra*).

(2) The following are limitations to services provided by outpatient hospitals:

(a) Each hospital shall comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply will result in denial of payment under the MA program.

(3) The following outpatient hospital services are not covered under the MA program:

(a) Hypoallergenic foods; baby foods.

(b) Diapers.

(c) Charges for services of house staff, interns, residents, administrative or supervisory staff

(including physician-owners) who are paid by the hospital or by other sources.

g. Clinic services. "Clinic services" are preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished to an outpatient by or under the direction of a licensed physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients. Family planning agencies or centers are considered "clinics" under this definition.

(1) "Family planning agencies" are agencies or clinics which primarily offer family planning related services and have executed either a contract or provider agreement with the state agency. Family planning agencies provide services concerned with the voluntary planning of the conception and bearing of children. Such services include both fertility and infertility programs.

(a) The following are limitations to services provided by family planning agencies:

(i) The request for such services must originate with the recipient and proceed with his full knowledge and consent.

(ii) The agency or clinic must comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply with these requirements will result in denial of payment under the MA program.

h. Home health care services.

(1) "Home health care services" are any of the following items and services when they are prescribed by a licensed physician to a patient in his place of residence, but excluding residence in a hospital, SNF or ICF:

(a) Intermittent or part-time nursing services furnished by a home health agency.

(b) Intermittent or part-time nursing services of a professional registered nurse or licensed practical nurse under the direction of the patient's physician, when no home health agency services are available.

(c) Medical supplies, equipment and appliances prescribed by a physician as necessary for the care of the patient and suitable for use in the home.

(d) Services of a home health aide under the supervision of a professional nurse assigned by a home health agency.

(2) A "home health agency" is a public or private agency or organization, or a subdivision of such an agency or organization, which is qualified to participate as a home health agency under Title XVIII of the Social Security Act or is determined by the Department of Health to currently meet the requirements of applicable federal regulations. The following home health care services are not covered under the MA program:

(a) Homemaker services.

(b) Social services provided by a home health agency.

i. Medical supplies. The term "medical supplies" as used herein includes the most cost effective non-durable medical supplies, durable medical equipment, prostheses, orthoses and oxygen. Medical supplies must be prescribed by a physician or other licensed medical practitioner within the scope of his profession as defined by state law. Medical supplies must be necessary and reasonable for the treatment or diagnosis of an illness or injury or to improve the functioning of a malformed body member.

(1) "Non-durable medical supplies". Those items which have a limited life expectancy (e.g., atomizers, nebulizers, fountain syringes and incontinence pads).

(2) "Durable medical equipment". Equipment which can withstand repeated use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home (e.g., wheel chairs, hospital beds and side rails).

(3) "Prostheses" and "orthoses". Replacement, corrective or supportive devices for the purpose of artificially replacing a missing portion of the body or to prevent or correct physical deformity or malfunction or to support a weak or deformed portion of the body.

(4) The MA program pays for oxygen and any equipment necessary for administration of oxygen (or other than nasal catheters and positive pressure breathing apparatus) when prescribed by a licensed physician so long as prior authorization is obtained.

Payment for equipment repair will be allowed only when that equipment is medically necessary. Routine periodic servicing such as testing, cleaning, regulating and checking of a recipient's equipment will not be covered. Extensive, complex maintenance may be covered as a necessary repair. Payment on equipment will not continue after the recipient's need for that equipment ceases to exist. The MA program will pay for supplies essential to the effective use of medically necessary durable equipment.

Eligible providers include those individuals or agencies who supply and/or service medical supplies. Medical supply and hearing aid dealers must complete a "Performance Agreement" to be eligible to participate in the MA program. Performance agreement as used herein means a written agreement between a provider of service and the state agency, as required by federal regulations.

(5) The following medical supplies must receive prior authorization:

(a) Non-durable medical supplies, when:

(i) The cost exceeds the performance agreement limitations;

(b) Durable medical equipment, when:

(i) The purchase, projected cumulative rental, repair or maintenance cost exceeds the performance agreement limitation;

(c) Prostheses and orthoses, when:

(i) The purchase, projected cumulative rental, or repair cost exceeds the performance agreement limitations;

(ii) The order is for an indwelling catheter (which requires a diagnosis of permanent urinary incontinence) or

(iii) The order is for a hearing aid, repairs to hearing aids when the costs of parts and labor exceeds the performance agreement limitations, repairs under the limitations, if performed by a hearing aid dealer more than once a year, or visits by a hearing aid dealer/servicer to the recipient's home in excess of one visit per year.

(d) Oxygen and any equipment necessary for the administration of oxygen, except in documented emergencies.

(e) Medical supplies for recipients who are residents of long term care facilities may be authorized under the following conditions:

(i) The cost of a specific item cannot be covered in the per diem rate; and

(ii) The item is necessary for the continuous care and exclusive use of this recipient to meet an unusual medical need; and

(iii) The need is identified and documented in the recipient's plan of care.

(6) The following items are not covered under the MA program:

(a) Equipment primarily and customarily used for non-medical purposes, i.e.:

(i) Air conditioners.

(ii) Food blenders.

(iii) Exercycles.

(iv) Orthopedic mattresses.

(v) Dehumidifiers.

(vi) Humidifiers.

(vii) Air filters.

(viii) Auto modifications.

(ix) Books.

(x) TV sets.

(xi) Bicycles.

(xii) Household items.

(xiii) Safety bars.

(xiv) Training equipment.

(b) Comfort or convenience items (i.e., electric beds, elevators, waterbeds, cushion lift chairs).

(c) Stock orthopedic shoes unless attached to a leg brace.

(d) Medical equipment and supplies for recipients who are residents of long term care facilities, except as provided in E.2. i (4)(e), *supra*.

(e) The three follow-up visits per year at the hearing aid dealer's office or service center specified in the Hearing Aid Performance Agreement.

(f) Reimbursement to long term care facilities for any medical equipment or supplies other than allowed under DPW 49 and 52.

j. Private duty nursing services. "Private duty nursing services" are nursing services provided by a professional registered nurse or a licensed practical nurse under the general direction of the patient's physician to the patient in his own home or in a hospital or SNF, when the patient requires individual and continual care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital or SNF. Eligible providers include registered nurses and licensed practical nurses in independent practice who provide services separate and apart from any employment or contract with any agency, organization or facility.

(1) The MA program pays for private duty nursing services only:

(a) When ordered in writing by the patient's primary physician or consulting physician;

(b) In hospitals having no intensive care unit capable of meeting the patient's needs;

(c) In the family residence when there is no available home health care agency to provide the required level of nursing care which meets the requirements for participation under Title XVIII of the Social Security Act.

(d) If the private duty nurse is not a member of the patient's family.

k. Rehabilitative and therapeutic services. "Rehabilitative and therapeutic services" are provided for the purpose of increasing or maintaining the maximum level of functional independence of patients. These services are defined as follows and include the use of such supplies and equipment as necessary, when pursuant to physician orders and when purchased by a facility, agency or independent practitioner.

(1) Rehabilitative and therapeutic services in long term care facilities. Such services must be provided in accordance with applicable federal regulations, state law and DPW rules.

(a) "Physical therapy". Those services prescribed by a physician and provided to a patient by a qualified physical therapist. In addition, other qualified rehabilitative personnel, including physical therapy assistants, physical therapy aides, and physical therapy orderlies may assist the physical therapist in performing physical therapy services and in the performance of duties that do not require a qualified physical therapist's knowledge and skill. The full responsibility for the patient's instruction or treatment remains with the qualified physical therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct, on-site observation and supervision by the qualified physical therapist. A "qualified physical therapist" is a graduate of a school of physical therapy approved by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association, and who has a valid Minnesota certificate of registration (as soon as such certificate is available from the Minnesota Department of Health).

(b) "Occupational therapy". Those services prescribed by a physician and provided to a patient by a qualified occupational therapist. In addition, other qualified rehabilitative personnel, including occupational therapy assistants, occupational therapy aides, and occupational therapy orderlies may assist the occupational therapist in performing occupational therapy services and in the performance of duties that do not require a qualified occupational therapist's knowledge and skill. The full responsibility for the patient's instruction or treatment remains with the qualified occupational therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct, on-site observation and supervision by the qualified occupational therapist. A "qualified occupational therapist" is a graduate of a school of occupational therapy approved by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, and/or who is registered by the American Occupational Therapy Association.

(c) "Services for individuals with speech, hearing and language disorders". Those diagnostic, screening, preventive or corrective services prescribed by a physician and provided by a qualified speech pathologist or a qualified audiologist in the practice of his profession. A "qualified speech pathologist" or "qualified audiologist" shall have a Certificate of Clinical Competence from the American Speech and Hearing

Association, or shall have completed the equivalent educational requirements and work experience necessary for obtaining such a certificate, or shall have completed the academic program and be in the process of accumulating the necessary supervised work experience required to qualify for such a certificate.

(d) Specialized rehabilitative service requirements — inpatient and outpatient.

(i) Restorative therapy. There must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonably and generally predictable period of time. This expectation shall be based on an assessment made by the attending physician of the patient's restorative potential after consultation with qualified rehabilitative personnel.

(ii) Specialized maintenance therapy. Physician orders must relate the necessity for specialized maintenance therapy to the patient's particular disabilities. Such therapy must be necessary for maintaining the patient's current level of functioning or for preventing deterioration of the patient's condition. Specialized maintenance therapy shall be provided only by qualified rehabilitative personnel and only to those patients who cannot be adequately and appropriately treated solely within the facility's nursing program.

(e) Billing and reimbursement.

(i) The long term care facility in which the recipient resides shall bill on behalf of the rehabilitative personnel, agency or hospital for services provided. In cases where a patient residing in a facility is provided specialized rehabilitative services in a setting other than his residential facility, the residential facility shall bill for services provided pursuant to agreement with the agency, hospital or other institution where the service is provided.

(ii) Reimbursement to qualified rehabilitative personnel (including rehabilitative assistants and aides) under contract with a facility: Each facility shall bill the MA program on behalf of qualified rehabilitative personnel providing services under contract to it.

(iii) Reimbursement to qualified rehabilitative personnel (including supervised rehabilitative assistants and aides) salaried by the facility. Each facility shall bill on behalf of salaried, qualified rehabilitative personnel for the services provided. At the end of each fiscal year, the facility shall:

(aa) Determine the total number of treatment sessions provided by each salaried, qualified rehabilitative employee during the fiscal year. A "treatment session" is defined as one or more treatment procedures and/or modalities provided to one patient during one session.

(bb) Determine, for each qualified rehabilitative employee, the total number of treatment sessions (as defined herein) provided to eligible recipients and indicate this number as a percentage of the total number of treatment sessions provided by that employee.

(cc) Multiply the resulting percentage by the salary of the employee. "Salary" means all direct costs related to employment. If Medical Assistance reimbursement exceeds the percentage of salary related to treatment sessions provided to Medical Assistance recipients, the excess amount shall be applied to and, therefore, reduce the "General and Administration" expenses on the health facility cost report submitted by the respective facility.

(f) The following rehabilitative and therapeutic services are not reimbursable as a separate charge under the MA program when furnished in a long term care facility:

(i) Services authorized by a physician but not documented in the patient's medical record.

(ii) Services provided by unsupervised assistants, aides and/or other supportive personnel. Salaries and costs related to these personnel are to be included as part of the facility's rate determination in accordance with the health facility cost report.

(iii) Rehabilitative services provided by nursing personnel.

(iv) Services for personal comfort.

(v) Services of qualified rehabilitative personnel related to training or consultation of facility staff.

(vi) Activities programs.

(vii) Services of a rehabilitative nature provided by living unit personnel, qualified mental retardation professionals, direct care staff, and training or habilitational personnel.

(viii) Screening procedures not ordered by a physician.

(ix) Services not reasonable and necessary to the treatment of the patient's condition.

(x) Services provided without written orders of the patient's attending physician.

(xi) Services provided without physician review of the patient's progress and plan of care at least once every 30 days, with written certification and recertification by the physician.

(xii) Services of a preventive or maintenance nature when physician orders do not relate such services to the patient's disabilities.

(xiii) Physical therapy services not authorized after the initial 90-day service period by an independent medical consultant or the facility's utilization review committee, or through the local welfare agency's approved review plan only if authorization by an independent medical consultant or the utilization committee is not possible.

(xiv) Outpatient services provided by a facility not certified as an outpatient provider.

(xv) Outpatient services provided off the facility's premises.

(xvi) Services billed for by any source other than the skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

(2) Speech pathology, audiology and physical therapy provided by independent practitioners. Such services are of a diagnostic, screening, preventive or corrective nature and provided to individuals with speech, hearing and language disorders or physical impairments. Such services must be provided in accordance with applicable federal regulations, state law and DPW rules.

(a) "Speech pathology". Those services prescribed by a licensed physician and provided to a patient by a qualified speech pathologist in independent practice. A "qualified speech pathologist in independent practice" shall have received a Certificate of Clinical Competence from the American Speech and Hearing Association [ASHA] or shall have submitted to the MA program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

(b) "Audiology": Those services prescribed by a licensed physician and provided to a patient by a qualified audiologist in independent practice. A "qualified audiologist in independent practice" shall have received the Certificate of Clinical Competence from ASHA or shall have submitted to the MA program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

(c) "Physical therapy". Those services prescribed by a licensed physician and provided to a patient by a qualified physical therapist in independent practice. A "qualified physical therapist in independent practice" is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, has a valid Minnesota Certificate of Registration (as soon as such certificate is available from the Minnesota Department of Health), and has been certified as an independent practitioner by the Minnesota Department of Health.

(d) The following services are not covered as independent practitioner services under the MA program:

(i) Services provided by an independent practitioner speech pathologist, audiologist or physical therapist not maintaining at his own expense an office or office space and the necessary equipment to provide an adequate treatment program.

(ii) Services which are not physician prescribed.

(iii) Any service authorized by a physician but not documented in the clinical record of the patient.

(iv) Training or consultation provided by a speech pathologist, audiologist or physical therapist to an agency, facility or other institution.

(v) Screening procedures not physician authorized.

(vi) Services provided under a written treatment plan which is not reviewed at least once every 30 days with certification and recertification by the ordering physician.

(e) The following services of independent practitioners must be billed through the contracting or employing facility, agency, or person and will not be reimbursed directly to the practitioner:

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(i) Services provided in settings other than the independent practitioner speech pathologist's, audiologist's or physical therapist's own office or the recipient's place of residence. "Place of residence" excludes skilled nursing facilities, intermediate care facilities, hospitals, rehabilitation agencies, home health agencies, public health agencies, clinics and day activity centers.

(ii) Services of a speech pathologist, audiologist or physical therapist employed and salaried by physicians.

(3) Rehabilitation agencies: An agency which provides an integrated multidisciplinary program designed to upgrade the physical function of handicapped, disabled individuals by bringing together as a team specialized rehabilitation personnel. At a minimum, a rehabilitation agency must provide physical therapy or speech pathology services, and a rehabilitation program which in addition to physical therapy or speech pathology services, includes social or vocational adjustment services. Eligible providers include all rehabilitation agencies participating in the Medicare program (Title XVIII) who have signed and returned to the state agency a provider agreement within sixty (60) days after receipt thereof. "Rehabilitation agency services" are those services provided by certified rehabilitation agencies in accordance with applicable federal regulations, state law and DPW rules and defined as follows:

(a) "Medical services". Those services provided to a patient within the scope and practice of medicine as defined by Minnesota law and performed by a currently licensed physician.

(b) "Psychological services". Those services provided to a patient by a psychologist licensed to practice in the appropriate service areas, when medically necessary.

(c) "Psychosocial services". Those services provided to a patient by a social worker for whom a licensed physician assumes total professional and administrative responsibility as if the services were provided by the physician himself. To receive reimbursement under the MA program all psychosocial services shall be ordered by a licensed physician.

(d) "Physical therapy". Those services prescribed by a licensed physician and provided to a patient by a qualified physical therapist. Other personnel may assist physical therapists in performing physical therapy services and in the performance of duties that do not require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified physical therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct on-site observation and supervision by the qualified physical therapist.

(e) "Occupational therapy". Those services prescribed by a licensed physician and provided to a patient by a qualified occupational therapist. Other personnel may assist occupational therapists in performing occupational therapy services and in the performance of duties that do not require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified occupational therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct on-site observation and supervision by the qualified occupational therapist.

(f) "Speech pathology or audiology services for individuals with speech, hearing and language disorders". Those diagnostic, screening, preventive or corrective services provided by a qualified speech pathologist or audiologist in the practice of his profession for which a patient is referred by a licensed physician.

(g) "Special services". Physician-ordered and monitored evaluations, classes, clinics or programs provided to patients generally by a rehabilitation team.

(h) The MA program will reimburse for services provided only by the following qualified personnel:

(i) Physicians. A qualified physician who is currently licensed in the State of Minnesota to practice medicine or, if an out-of-state physician, who is licensed in the state of service.

(ii) Psychologists. A qualified psychologist who is currently licensed by the Minnesota State Board of Examiners of Psychologists as a licensed consulting psychologist or a licensed psychologist.

(iii) Social workers. A qualified social worker is an individual with a master's degree from a school of social work accredited by the Council on Social Work Education.

(iv) Physical therapists. A qualified physical therapist is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, and, has a valid Minnesota Certificate of Registration.

(v) Occupational therapists. A qualified

occupational therapist is a graduate of a school of occupational therapy approved by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, and/or who is registered by the American Occupational Therapy Association.

(vi) Speech pathologists and audiologists. A qualified speech pathologist or audiologist is an individual with a Certificate of Clinical Competence from the American Speech and Hearing Association or an individual who has completed the equivalent educational requirements and work experience necessary for obtaining such a certificate, or, who has completed the academic program and is in the process of accumulating the necessary supervised work experience required to qualify for such a certificate.

(i) Rehabilitation agencies — non-covered services include:

(i) Services provided without physician orders (excluding psychological services).

(ii) Psychosocial services provided by a social worker when a licensed physician does not assume professional and administrative responsibility for such services.

(iii) Services authorized by a physician but not documented in the patient's clinical record.

(iv) Services provided in day activity centers which are subsidiaries of rehabilitation agencies.

1. Dental services. "Dental services" are diagnostic, preventive or corrective procedures administered by or under the supervision of a licensed dentist. The MA program pays for all emergency care and basic medically necessary oral health needs. "Dentures" are artificial structures prescribed by a dentist to replace a full or partial set of teeth and made by or according to the directions of a licensed dentist. Eligible providers are dentists licensed to practice dentistry in Minnesota, another state or a Canadian province.

(1) The following dental services and procedures must receive prior authorization:

(a) Pedodontics (only when the secondary tooth has completed two-thirds of its development).

(b) Hospitalization for dental treatment.

(c) Periodontics.

(d) Root canal therapy (molars only and only if more than one needs treatment).

(e) Gold restorations and/or inlays (including cast non-precious and semi-precious metals).

(f) Fixed prosthodontics.

(g) Orthodontics.

(h) Surgical services except emergencies and alveolectomies.

(i) Removal of impacted teeth.

(2) The following are limitations on the MA dental program:

(a) Oral hygiene instruction — 1 time only.

(b) Dentures (any type) — 1 per 5 year period, except under special circumstances and only then if prior authorization is received. Dentures that are lost and/or destroyed by recipient negligence will not be replaced during such 5 year period.

(c) Relines or rebase — 1 every 3 years, except under special circumstances and only then if prior authorization is received.

(d) Patients in hospitals or long term care facilities — 3 visits by the dentist to the hospital or LTC facility per diagnosis. (as used here, "diagnosis" means evaluation, determination of medical condition and plan of treatment. This limitation applies to inpatient hospital facilities only if the recipient has been hospitalized in order to treat a dental condition. This does not limit the number of visits a recipient can make to the dentist's office.)

(3) The following services are not covered under the MA dental program:

(a) Additional clasps for partial dentures.

(b) Bases.

(c) Sealants.

(d) Local anesthetics when billed as a separate procedure.

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(e) Toothbrushes and/or other hygiene aids.

(f) Services provided to a recipient in his home.

m. Other laboratory and x-ray services. "Other laboratory and x-ray services" include professional and technical laboratory and radiological service ordered by a licensed physician, dentist or other licensed practitioner within the scope of his practice as defined by state law and who is not employed by that laboratory. The MA program shall pay for such services only when provided by or under the direction of a physician or licensed practitioner in an office or similar facility other than a hospital outpatient department or clinic. Such laboratory must be qualified to participate under Title XVIII of the Social Security Act, or be currently determined to meet the requirements for such participation. Eligible providers are facilities that render professional and technical laboratory services as described herein.

n. Pharmacy services. A "pharmacy" is a facility licensed by the State Board of Pharmacy in which prescriptions, drugs, medicines, chemical and poisons are compounded, dispensed, vended or sold on a retail basis. "Prescribed drugs" are any simple or compounded substance or mixture of substances prescribed for the care, mitigation or prevention of disease or for health maintenance, by a physician, dentist or other licensed medical practitioner within the scope of his professional practice as defined by state law. The MA program covers prescribed drugs obtained from a licensed pharmacy or from a hospital in which drug dispensing is under the supervision of a licensed pharmacist. All licensed pharmacies are eligible to participate in the MA program when the pharmacist in charge has enrolled as a provider in accordance with state agency requirements. The MA program shall pay for pharmaceuticals prescribed and dispensed by a physician or dentist in his office when there is no licensed pharmacy within the recipient's local trade area, as defined in D.1., *supra*.

(1) The following are service limitations of the MA pharmacy program:

(a) Pharmaceuticals must be prescribed by a licensed physician, dentist or other authorized licensed practitioner of the healing arts. The drug dispenser must keep the signed prescription on file for 5 years, subject to audit at any reasonable time (See, D.4.c., *supra*).

(b) Telephone orders, where legal, must be reduced to writing with the name of the prescribing physician shown and must be signed by the pharmacist.

(c) Prescription refills:

(i) The prescriber must indicate, either verbally or by specification on the original prescription, approval for refilling the prescription.

(ii) As many as five (5) refills may be authorized by the prescriber, but in such cases the total amount authorized must be dispensed within six (6) months of the original prescription date, except when the patient is in a long term care facility where no such limit shall exist.

(iii) In the absence of specific refill instructions, the prescription will be interpreted to be not refillable. Refills are covered only when refilled by the pharmacy where the original presciption was filled.

(d) The quantity supplied will depend on the usual and customary prescribing practice of the physician provided that the quantity does not exceed 30 days for acute illness and 100 days for maintenance therapy.

(2) The following services must receive prior authorization:

(a) Supplemental and tube feedings for patients who have special nutritional needs. The patient's dietary requirements must be identified on a physician's prescription and the product(s) must be available from an eligible supplier.

(3) The following items are not covered under the MA pharmacy program:

(a) Non-legend drugs, stocked by a long term care facility and administered to a patient in such facility for short term (up to 36 hours) therapy.

(b) Cosmetic products (including hypoallergenic cosmetics).

(c) Toiletries (non-medicated soaps, body lotions, powders) used for personal cleaning and grooming.

(d) Oral antiseptics.

(e) Dentifrices and other dental hygiene equipment and supplies.

(f) Throat lozenges.

(g) Contact lens wetting solutions and cleaners.

(h) Investigational drugs.

(i) Biologicals (i.e., vaccines, serums, tox-

oids) generally considered inappropriate for self-administration.

(j) Amphetamines, amphetamine derivates and any other Drug Enforcement Agency Schedule II anorexient agents for weight control purposes, except as provided in E.1.n., *supra*.

(k) Nutritional services:

(i) Modified diets consisting of conventional foods.

(ii) Salt and sugar substitutes; salt or sugar-free specialty food and beverage products.

(iii) Baby foods.

(iv) Hypoallergenic foods (See, E.2.n(2), *supra*).

(v) Alcoholic beverages.

(l) Any medication not prescribed by a licensed physician, dentist or other licensed practitioner authorized by the state to prescribe drugs within the scope of his practice.

o. Other diagnostic, screening, preventive and rehabilitative services. The MA program provides for these services as described herein.

(1) "Diagnostic services", other than those for which provision is made elsewhere in this rule, include any medical procedure or supplies recommended for a patient by his physician or other licensed medical practitioner within the scope of his practice as defined by state law, as necessary to enable him to identify the existence, nature or extent of illness, injury or other health deviation of the patient.

(2) "Screening services" consist of the use of standardized tests performed under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations, or to identify suspects for more definitive studies.

(3) "Preventive services" are those services provided by a licensed physician or other licensed medical practitioner within the scope of his practice as defined by state law, to prevent illness, disease, disability and other health deviations or their progression, and to prolong life and promote physical and mental health efficiency.

(4) "Rehabilitative services" include any medical remedial items or services, except those expressly excluded under this rule, which are prescribed by a licensed physician or other licensed medical practitioner within the scope of his practice as defined by state law, for the purpose of reducing physical or mental disability and restoring the patient to his best possible functional level. Prior authorization must be obtained on any services for which payment is claimed under this section.

p. Early periodic screening, diagnosis and treatment (EPSDT). The MA program provides for early and periodic screening and diagnosis of individuals under the age of 21 to ascertain physical or mental defects and for health care, treatment and other measures to correct or ameliorate defects and any chronic conditions discovered thereby. Services rendered by providers other than licensed physicians are reimbursable only if the Minnesota Department of Health has previously approved the screening activities.

(1) In order to comply with federal and state EPSDT requirements, local welfare agencies shall:

(a) Notify in writing on an annual basis all recipients eligible for EPSDT services about the existence of such services;

(b) Provide or arrange for provision of screening services when they are requested;

(c) Arrange for needed corrective treatment; and

(d) Maintain adequate EPSDT records and report activities as required by federal and state agencies.

(2) In order to comply with federal and state EPSDT requirements, providers shall:

(a) Follow required EPSDT billing/reporting procedures;

(b) Adhere to free choice of provider policy when making referrals for recipients.

q. Health care insurance premiums. The MA

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program shall pay health insurance premiums determined by the state agency to be cost-effective, for:

(1) Eligible recipients not covered under Title XVIII of the Social Security Act, when coverage under the insurance policy justifies the premium charged and the policy provides coverage only for health care.

(2) Supplemental medical insurance (SMI) on a buy-in basis for eligible recipients covered under Title XVIII of the Social Security Act.

(3) Such other insurance programs as the state agency may approve for eligible recipients.

r. Other medical care. The MA program shall pay for other necessary medical and/or remedial care as follows:

(1) Transportation only when furnished by an enrolled medical provider licensed by the Minnesota Department of Health (See, D.7., *supra*).

(a) The following services rendered by medical transportation providers are not covered under the MA program:

(i) Any routine service determined by the local welfare agency not to be medically necessary.

(ii) Ambulance service in cases where another means of transportation would have sufficed.

(2) Emergency hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital equipped to furnish such services even though the hospital does not currently meet the conditions for participation under Title XVIII of the Social Security Act or the definitions of inpatient or outpatient services.

(3) Personal care services in a recipient's home rendered by an individual, other than a member of the patient's family, who is qualified to provide such services, when the services are prescribed by a physician and supervised by a registered nurse in accordance with a plan of treatment.

(4) Whole blood, including items and services required in the collection, storage and administration thereof, when it has been ordered by a licensed physician and is not available to the patient from other sources.

(5) Crippled children services program (CCS). Pursuant to a cooperative agreement between the Minnesota Department of Public Welfare and the Minnesota Department of Health, DPW will reimburse the state's CCS program (Title V) for diagnosis, evaluation and ongoing medical follow-up services in CCS field clinics for Medical Assistance eligible children up to 21 years of age. DPW will also reimburse CCS for evaluation, diagnosis and/or consultation provided Medical Assistance eligible children who are residents of the Minnesota School for the Deaf, the Minnesota School for the Blind and Visually Handicapped and certain other state institutions.

s. Mental health centers. "Mental health centers" are centers currently receiving grant-in-aid who are operating in accordance with DPW 28. Services provided by mental health centers must be provided under the auspices and direction of a psychiatrist licensed to practice medicine in the U.S. or Canada or a licensed consulting psychologist, currently enrolled as an eligible provider under the MA program. The MA program will pay for mental health center services provided to residents of long term care facilities only if the attending physician helped develop the plan of treatment and periodically reviews that plan.

(1) Mental health centers are subject to the same service limitations and prior authorization requirements as is the practitioner under whose auspices or direction the services are rendered (See, E.2.c.(1) and (2) and E.2.e.(4), *supra*).

(2) The following mental health center services are not covered under the MA program:

(a) Community planning.

(b) Community consultation; program consultation.

(c) Program and service monitoring and evaluation.

(d) Public information and education.

(e) Resource development.

(f) Training and education.

F. Reimbursement.

1. Payments to eligible providers. Participation in the MA program is limited to those providers of medical care, service and supplies who accept as payment in full amounts paid in accordance with DPW's maximum allowable charges. Providers are prohibited from requesting or receiving additional payment from the recipient,

his relatives or guardian, except to meet the spend-down provision of state law. Providers will be directly paid for providing medical care and services rendered within the scope of practice recognized under federal and state law and regulations. The state agency or, where appropriate, the local welfare agency, may pay an agency, institution or group pursuant to a contract with an approved provider only if required under a written contract between the provider and the agency, institution or group. The state agency shall have access to all such contracts at its request.

2. Billing procedures. Providers of medical care and services shall bill the state agency up to their usual and customary fee and only after the medical care or services have been provided. Providers proven to consistently bill in excess of their usual and customary fee shall be referred to the SURS program for investigation and, if appropriate, shall be determined ineligible to participate in the MA program. Medical bills should be presented for payment at the conclusion of each month's service. Providers shall bill within twelve (12) months of the date of service or, in unusual circumstances, in accordance with applicable federally-imposed time restrictions. The state agency shall deny payment until the following criteria have been met:

a. Providers submit all necessary forms and reports to the appropriate state or local welfare agency.

b. All prior authorization requirements are fulfilled.

c. Providers bill for care or services rendered on prescribed forms according to state agency instructions.

(1) The state agency shall require providers to submit diagnosis and procedure codes on all billings when deemed necessary for proper administration of the MA program, to comply with applicable federal regulations and to maximize federal financial participation.

d. Providers shall bill the state agency directly, except as follows:

(1) Where a written contract or other formal arrangement exists between the provider of the service and any agency, institution or group, in which case such agency, institution or group shall bill the state agency.

(2) If a provider of service who is eligible to accept Medicare assignments wishes to be paid by the MA program, such provider shall accept assignments on Medicare billings and shall bill Medicare prior to billing the MA program.

3. Authority to recover from medical providers. The state agency is authorized to recover any Medical Assistance funds paid to providers when it determines that such payment was obtained fraudulently or erroneously. Such recovery may be accomplished through withholding current obligations due the provider or by demanding that the provider refund amounts so received. Recovery under the MA program is permitted for intentional as well as unintentional error on the part of the provider or state or local welfare agency; for failure to comply fully with all utilization control requirements, prior authorization procedures or billing procedures; for failure to properly report third-party payments; and for fraudulent actions on the part of the provider.

G. Miscellaneous.

1. Former DPW 47 is hereby repealed except section S which becomes section F.4.

Department of Health

Emergency Rules Governing Public Water Supplies

Notice is given that emergency rules relating to public water supplies, MHD 145-149, which were adopted by the State Board of Health by resolution on May 12, 1977, and published in the *State Register* on June 6, 1977, are hereby re-issued and shall remain in effect as temporary rules until December 5, 1977, or until the rules take permanent effect, whichever occurs first.

Warren R. Lawson, M.D.
Commissioner of Health

KEY: Existing rules are printed in standard type face, Proposed additions to existing rules are printed in **boldface**, while proposed deletions from existing rules are printed within [single brackets]. Additions to proposed rules are **underlined and boldfaced**, while deletions from proposed rules are printed within [[double brackets]].

PROPOSED RULES

Office of Hearing Examiners

Proposed Rules Governing the Determination of Transmission Line Routes and Sites for Electric Generating Plants

The proposed new rules relating to the siting of large electric power generating plants and the routing of high voltage transmission lines are identical to the temporary rules adopted by the Chief Hearing Examiner on July 1, 1977, and as were published at State Register, Volume 2, No. 2, p. 85, July 18, 1977, (2 S.R. 85) except that the following new language is proposed to be added to HE 403:

The request shall include a statement by the Board that the facilities where the hearings are to be conducted are free of mobility barriers in accordance with Executive Order No. 148.

Proposed Rules Governing Rulemaking Procedures, Contested Case Hearings, Transmission Line Routes and Sites for Electric Generating Plants

Notice of Hearing

Notice is hereby given that public hearings in the above-entitled matters will be held pursuant to Minn. Stat. § 15.0412, subd. 4, at the following dates, times and places, and continuing until all persons have had an opportunity to be heard:

1. **October 11, 1977**: William Mitchell College of Law Auditorium, 875 Summit Avenue, **St. Paul**, Minnesota. At 9:30 a.m., the hearing will include the full, affirmative presentation by the Office of Hearing Examiners regarding amendments to the procedures for rulemaking and contested case hearings. At 1:30 p.m., the hearing will be solely for the presentation of the proposed rules of procedure for the routing of high voltage transmission lines and the siting of large electric power generating plants. At 7:00 p.m., the Office of Hearing Examiners will summarize the proposed power line/plant rules and allow persons to comment thereon.

Note: At all of the following hearings, which will begin at 7:00 p.m., a summary of the amendments to the existing rules and the newly proposed power line/plant rules will be presented by the Office of Hearing Examiners. Copies of the Statement of Need and Summary of Evidence will be available for review. The primary purpose of the hearings is to allow interested persons to comment on the proposals.

2. **October 12, 1977**: Council Chambers, City Hall, **Duluth**, Minnesota.

3. **October 13, 1977**: Hagg-Sauer Auditorium, Bemidji State University, **Bemidji**, Minnesota.

4. **October 17, 1977**: Vocational-Technical Institute Cafeteria, **Alexandria**, Minnesota.

5. **October 19, 1977**: Room P223, Plaza West Building, Rochester Community College, **Rochester**, Minnesota.

6. **October 20, 1977**: Centennial Student Union Conference Auditorium, Mankato State University, **Mankato**, Minnesota.

All interested or affected persons will have the opportunity to participate concerning the amendments to the existing rules and the adoption of the proposed new rules. Statements may be made orally and written material may be submitted, whether or not an appearance is made at the hearings, by mail to Allan W. Klein, Room 300, 1745 University Avenue, St. Paul, Minnesota 55104, telephone (612) 296-8114, either before, during or within 20 calendar days after the last hearing date.

All persons have the right to be notified of the date on which the Hearing Examiner'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. All persons have the right to be informed of the date on which the hearing record has been submitted to the Attorney General by the agency. If you desire to be so notified, you may do so by so indicating at the hearing or by written request sent to the Hearing Examiner prior to the close of the record.

Notice is hereby given that 25 days prior to the first hearing date, a Statement of Need and Summary of Evidence will be available for review at the Office of Hearing Examiners. Such statement has been prepared as a single document but in separate parts. The first part relates solely to the proposed amendments to the existing rules relating to rulemaking and contested case proceedings. The second part relates solely to the new proposed rules relating to procedures for hearings for power lines and power plants. Copies of these documents will be available for review at each hearing. These documents include the verbatim testimony intended to be presented at the hearing on October 11, 1977, justifying both the need for and reasonableness of the proposed rules. Copies of the statements may be obtained from the Office of Hearing Examiners by sending a

written request, together with a check, money order or cash (no stamps) payable to: State Treasurer, Hearing Examiners Account, in the following amounts:

1. Rulemaking and Contested Case only: $3.55

2. Power line and power plants only: $2.05

3. Complete document: $5.60

Copies of the proposed amendments to the existing rules and the new rules are now available, and one free copy may be obtained by writing the Office of Hearing Examiners, 1745 University Avenue, St. Paul, Minnesota 55104. Persons desiring copies should indicate whether they desire all proposals or which portions they desire in order to conserve costs. Copies will also be available at all hearings.

Statutory authority to adopt the proposed amendments is contained in Minn. Stat. § 15.052, subd. 4. Statutory authority to adopt the newly proposed procedures relating to power line/plants is contained in Laws of Minnesota, 1977, ch. 439, § 22.

The proposed amendments to the rulemaking procedures, if adopted, would clarify existing rules which have led to confusion; conform the rules to legislative changes; provide for better notice to the public of their statutory rights; insure that all hearings will be conducted in barrier-free facilities; provide for better notice; combine the Statement of Need and Summary of Evidence into a single document; provide a procedure for advance approval for incorporation by reference; delete the requirement of submitting all of the record to the Chief Hearing Examiner for his review for substantial change; and provide an effective date.

The proposed amendments to the contested case procedures, if adopted, would clarify existing rules which have led to confusion; conform the rules to legislative changes; insure that all hearings will be conducted in barrier-free facilities; combine the Order for Hearing, Notice of Hearing and Statement of Charges or Issues into a single document; provide for better notice of the results occurring from a default; provide for alternative notice procedures; clarify the procedures relating to the Notice of Appearance; provide for consolidation of similar petitions for intervention; broaden the extent of public participation; provide for automatic reassignment of a Hearing Examiner upon the filing of an Affidavit of Prejudice; provide a new rule relating to motions; change discovery procedures to recognize all privileged communications recognized at law and broaden discovery in general; provide a new rule protecting proprietary information; provide a new rule relating to an Offer of Proof; changing the rule relating to certification of motions to the agency; and provide that a copy of an agency final order shall be sent to the Hearing Examiner.

The proposed rules relating to power lines and power plants, if adopted, would be quite similar to the existing rules relating to contested cases but reflect the legislative mandate to provide for the broadest possible citizen participation. The rules provide a procedure whereby the direct testimony of all parties is to be prefiled at least 14 days before the hearing, not only with the Hearing Examiner, the Environmental Quality Board and all parties, but at a library or other location selected by the Environmental Quality Board in each affected county. Under the rules, the hearings would be conducted in two stages. The first stage would start with the cross-examination of the parties' witnesses by other parties. The second stage will be solely for the purpose of allowing interested persons an opportunity to question witnesses and present their own testimony and evidence. Interested persons may give testimony orally or in writing, with or without benefit of oath, and may submit questions for the witnesses in written form to the Hearing Examiner. The Notice of Hearing will inform the public of the specific dates and places where each witness will be available for questioning and where the public participation will be started.

Please be advised that Minn. Stat. ch. 10A requires each lobbyist to register with the Ethical Practices Board within 5 days after he commences lobbying. Lobbying includes attempting to influence rulemaking by communicating or urging others to communicate with public officials. A lobbyist is generally any individual who spends more than $250 per year for lobbying or any individual who is engaged for pay or authorized to spend money by another individual or association and who spends more than $250 per year or 5 hours per month at lobbying. The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, St. Paul, Minnesota 55155, phone: (612) 296-5615.

Duane R. Harves
Chief Hearing Examiner

Rules as Proposed

HE 102-112 Rulemaking procedures.

HE 102 [(b)] **B.** [A proposed] **The** Order for Hearing **proposed to be issued**. The [proposed] Order for Hearing must contain the following:

KEY: Existing rules are printed in standard type face. Proposed additions to existing rules are printed in **boldface**, while proposed deletions from existing rules are printed within [single brackets]. Additions to proposed rules are **underlined and boldfaced**, while deletions from proposed rules are printed within [[double brackets]].

[(1)] **1.** A proposed time, date and place for the hearing to be held.

[(2)] **2.** A statement that the Notice of Hearing shall be given to all persons who have registered with the Secretary of State for that purpose and a statement that the Notice of Hearing shall be published in the *State Register*.

[(3)] **3.** The signature of the person authorized to order a hearing. If a board is ordering the hearing, the person signing the order must be so authorized and a document of authority must be attached to the Order for Hearing.

HE 102 [(c)] **C.** [A proposed] **The** Notice of Hearing **proposed to be issued** must contain the following:

[(1)] **1.** A proposed time, date and place for the hearing to be held.

[(2)] **2.** A statement that all interested or affected persons will have an opportunity to participate.

[(3)] **3.** A statement or a description of the subject and issues involved. If the proposed rules themselves are not included with the Notice of Hearing, then the Notice must clearly indicate the nature and extent of the proposed rules and a statement shall be included announcing the availability and the means of obtaining upon request at least one free copy of the proposed rules.

[(4)] **4.** A citation to the agency's statutory authority to promulgate the proposed rules.

[(5)] **5.** A statement describing the manner in which interested persons may present their views.

[(6)] **6.** A statement advising interested persons that lobbyists must register with the State [Ethics Commission,] **Ethical Practices Board**. [which statement shall be substantially as follows:

Under Minn. Stat. § 10A.01, subd. 11 (1974), any individual engaged for pay or other consideration for the purpose of representing persons or associations attempting to influence administrative action, such as the promulgation of these rules, must register with the State Ethics Commission as a lobbyist within five days of the commencement of such activity by the individual.]

[(7)] **7.** A statement that written material may be submitted and recorded in the hearing record for [20] **five working** days after the public hearing ends, **or for a longer period not to exceed 20 days if ordered by the hearing Examiner.**

8. A separate paragraph which shall read as follows:

Notice: All persons have the right to be notified of the date on which the Hearing Examiner'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. All persons have the right to be informed of the date on which the hearing record has been submitted to the Attorney General by the agency. If you desire to be so notified, you may do so by so indicating at the hearing or by written request sent to the Hearing Examiner prior to the close of the record.

9. A separate paragraph which shall read as follows:

Notice is hereby given that 25 days prior to the hearing a statement of need and reasonableness will be available for review at the agency and at the Office of Hearing Examiners. This statement of need and reasonableness will include a summary of all of the evidence which will be presented by the agency at the hearing justifying both the need for and the reasonableness of the proposed rule/rules. Copies of the statement of need and reasonableness may be obtained from the Office of Hearing Examiners at a minimal charge.

10. A statement which fulfills the requirements of Minn. Stat. § 15.0412, subd. 7, relating to the expenditure of public monies by local public bodies.

HE 102 [(d)] **D.** A statement by the agency of the [number of persons expected to attend the hearing and the] estimated length of time that will be necessary **for the agency to present its evidence** [to conduct] **at** the hearing, **a statement by the agency that the facility where the hearing is to be conducted is free of mobility barriers in accordance with Executive Order No. 148, and a statement by the agency of what additional notice, if any, has been given pursuant to HE 103.**

Within ten days of receipt of the aforementioned documents, the Chief Hearing Examiner shall appoint a Hearing Examiner to preside at the hearing and the Hearing Examiner shall advise the agency as to the location at which and time during which a hearing should be held so as to allow for participation by all affected interests. **Failure of the agency to comply with the advice of the Hearing Examiner may result in a finding that the agency has failed to fulfill all relevant, substantive and procedural requirements of law or rule.**

HE 103 Notice. The Notice of Hearing shall be given pursuant to the provisions of Minn. Stat. § 15.0412, subd. 4, and in addition thereto, the agency should, within reason, attempt to give notice to all other persons or associations known to it to be persons who will be affected by the proposed rule/rules.

HE 104 Statement of need and reasonableness. Each agency desiring to adopt rules shall prepare a Statement of Need and Reasonableness which shall be prefiled pursuant to HE 105. The Statement of Need and Reasonableness shall be a document containing, at the minimum, a summary of all of the evidence and argument which will be presented by the agency at the hearing justifying both the need for and the reasonableness of the proposed rule/rules, including citations to any statutes or case law to be relied upon, citations to any economic, scientific or other manuals or treatises to be utilized at the hearing, and a list of any expert witnesses to be called to testify on behalf of the agency, together with a brief summary of the expert opinion to be elicited.

The statement shall be prepared with sufficient specificity so that interested persons will be able to fully prepare any testimony or evidence in favor of or in opposition to the rule/rules as proposed. Presentation of evidence or testimony not summarized in the Statement of Need and Reasonableness may result in the Hearing Examiner, upon proper motion made at the hearing by any interested person, recessing the hearing to a future date in order to allow all interested persons an opportunity to prepare testimony or evidence in opposition to such newly-presented evidence or testimony, which recessing shall be for a period not to exceed 25 calendar days, unless the 25th day is a Saturday, Sunday, or legal holiday, in which case, the next succeeding working day shall be the maximum date for the resumed hearing.

If the agency so desires, the Statement of Need and Reasonableness may contain the verbatim affirmative presentation by the agency which may then be either read at the hearing or, if all persons appearing at the hearing have had an opportunity to review the statement, may be introduced as an exhibit into the record as though read. In such instance, agency personnel or other persons preparing the statement shall be available at the hearing for questioning by the Hearing Examiner and other interested persons.

HE [103] **105** Documents to be filed before hearing. At least 25 days prior to the date and time of the hearing, the agency shall file with the Chief Hearing Examiner or his designee copies of the following documents:

[(a)] **A.** The Order for Hearing.

[(b)] **B.** The Notice of Hearing as mailed.

[(c)] **C.** The affidavit of receipt of the Secretary of State's list.

[(d)] **D.** [The] **An** Affidavit of Mailing **the Notice to all persons on the Secretary of State's list.**

[(e)] **E.** The Statement of Need **and Reasonableness.**

[(f)] **F.** The petition requesting a rule hearing, if one has been filed pursuant to Minn. Stat. § 15.0415.

[(g)] **G.** All materials received following a notice made pursuant to Minn. Stat. § 15.0412, subd. 5, together with a citation to said notice.

[(h)] **H.** The names of agency personnel who will represent the agency at the hearing together with the names of any other witnesses **who may appear** [appearing] on behalf of the agency.

[(i) A statement summarizing the evidence to be presented at the hearing in support of the proposed rules, including citations to any statutes or case law to be relied upon, citations to any economic, scientific or other manuals or treatises to be utilized at the hearing and a list of any expert witnesses to be called to testify on behalf of the agency together with a brief summary of the expert opinion to be elicited.]

HE [104] **106** Conduct of hearings. All hearings held pursuant to Minn. Stat. § 15.0412 shall proceed substantially in the following manner:

[(a)] **A.** All persons intending to present evidence or questions, other than agency personnel previously disclosed to the Hearing Examiner under HE 103, shall register with the Hearing Examiner prior to their presentation of evidence or questions by writing their names, addresses, telephone numbers and the names of any individuals or associations that the persons represent in connection with the hearing, on a register to be provided by the [agency] **Hearing Examiner, which register shall also include a section where persons may indicate their desire to be informed of the date on which the Hearing Examiner's Report will be available and the date on which the agency submits the record to the Attorney General.**

[(b)] **B.** The Hearing Examiner shall convene the hearing at the proper time and shall explain to all persons present the purpose of the hearing and the procedure to be followed at the hearing. The Hearing Examiner shall notify all persons present that the record will remain open for [20] **five working** days following the hearing, **or for a longer period not to exceed 20 calendar days if ordered by the Hearing Examiner**, for the receipt of written statements concerning the proposed rule or rules.

KEY: Existing rules are printed in standard type face. Proposed additions to existing rules are printed in **boldface**, while proposed deletions from existing rules are printed within [single brackets]. Additions to proposed rules are **underlined and boldfaced**, while deletions from proposed rules are printed within [[double brackets]].

[(c)] **C.** The Hearing Examiner shall advise the persons present of the requirements of [Minn. Stat. § 10A.01, subd. 11 (1974)] **Minn. Stat. ch. 10A** concerning the registration of lobbyists.

[(d)] **D.** The agency representatives and any others who will be presenting the agency position at the hearing shall identify themselves for the record.

[(e)] **E.** The agency shall make available copies of the proposed rule at the hearing.

[(f)] **F.** The agency shall introduce its exhibits relevant to the proposed rule including written material received prior to the hearing.

[(g)] **G.** The agency shall make its affirmative presentation of facts showing the need for and the reasonableness of the proposed rule and shall present any other evidence it deems necessary to fulfill all relevant, substantive and procedural, statutory or regulatory requirements.

[(h)] **H.** Interested persons shall be given an opportunity to address questions to the agency representatives or witnesses.

[(i)] **I.** Interested persons shall be given an opportunity to be heard on the proposed rule and/or to present written evidence. All interested persons submitting oral [or written] statements are subject to questioning by representatives of the agency. Interested persons may also be questioned by other non-agency persons present if they so consent.

HE [105] **107** The record. The record shall be closed upon the last date for receipt of written statements. [A court reporter from the Office of Hearing Examiners shall keep a record at each hearing unless the Chief Hearing Examiner determines that the use of an audiomagnetic recording device is more appropriate. The verbatim record will be transcribed and copies available to persons requesting them at a reasonable charge.] **The record in each hearing shall include all of the documents enumerated in HE 105, all written comments received prior to, during or subsequent to the hearing, and a tape recording of the hearing itself unless the Chief Hearing Examiner has determined that the use of a reporter is more appropriate. In the event a transcript of the proceedings has been prepared, it shall be part of the record, and copies will be available to persons requesting them at a reasonable charge.** The charge shall be set by the Chief Hearing Examiner, and all monies received for transcripts shall be payable to the State Treasury and shall be deposited in the Office of Hearing Examiners' account in the State Treasury. The agency **and any other person so requesting** shall be notified of the date of the completion of the transcript.

HE 108 Incorporation by reference. When an agency desires approval of the Chief Hearing Examiner to incorporate certain materials by reference in its rule, such approval must be obtained prior to the publication of the proposed rules in the *State Register*. The agency shall submit its request in writing and shall include with the request, the materials sought to be incorporated and shall further indicate to the Chief Hearing Examiner where the materials are conveniently available for viewing, copying and acquisition by interested persons. The Chief Hearing Examiner shall have ten working days to approve or disapprove the request. The agency shall maintain a copy of the incorporated materials as long as the adopted rule is in effect.

HE [106] **109** Report of the hearing examiner. Subsequent to the close of the record and the completion of the transcript of the hearing, the Hearing Examiner shall make his report pursuant to Minn. Stat. § 15.052, subd. 3, and shall file the original of said report **together with the complete record of the proceedings** with the agency [and a copy with the Chief Hearing Examiner.] The [agency] **Office of Hearing Examiners** shall make a copy of said report available to any interested person upon request **at a reasonable charge.** [The Hearing Examiner's report shall state his findings of fact and his conclusions and recommendations, taking notice of the degree to which the agency (a) documented its statutory authority to take the proposed action, (b) fulfilled all relevant, substantive and procedural requirements of law or rule, and (c) demonstrated the need for and reasonableness of its proposed action with an affirmative presentation of facts.]

HE [107] **110** Submission of rule to chief hearing examiner. [No earlier than ten days subsequent to the receipt of the Hearing Examiner's report,] [t]The agency shall, if it proposes to adopt the rules as originally proposed or amended, submit [the complete hearing record] **a copy of the Order Adopting Rules, a copy of any additional agency findings, a copy of the rules as originally proposed, and a copy of the rules as adopted** to the Chief Hearing Examiner, [including the rule as originally proposed, and the rule as proposed for adoption in its final form, should there be any difference,] for review pursuant to Minn. Stat. § 15.052, subd. 4. The submission to the Chief Hearing Examiner shall precede review by the Attorney General. The Chief Hearing Examiner shall complete his review and submit his report to the agency on the issue of substantial changes in the rule within ten calendar days. The agency will be responsible for filing the rules with the Attorney General.

HE [108] **111** Reconvened hearings. Should the Chief Hearing Examiner find, after a review of the record, that the proposed final rule is substantially different from the rule which was proposed at the public hearing, or should the Chief Hearing Examiner find that the agency failed to meet the requirements of **Minn. Stat. ch. 15 or** these rules, then

the Chief Hearing Examiner shall forthwith notify the agency and the Attorney General of said finding. The agency shall then either withdraw the proposed final rule or reconvene the rule hearing. The reconvening of the rule hearing shall comply with all statutory and regulatory requirements as if a new rule hearing were being held. In determining whether the proposed final rule is substantially different, the Chief Hearing Examiner shall consider the degree to which it:

[(1)] **A.** Affects classes of persons not represented at the previous hearing; or

[(2)] **B.** Goes to a new subject matter of significant substantive effect; or

[(3)] **C.** Makes a major substantive change that was not raised by the original Notice of Hearing in such a way as to invite reaction at the hearing; or

[(4)] **D.** Results in a rule fundamentally different from that contained in the Notice of Hearing.

HE [109] 112. Effective date. These rules shall be effective for all rule proceedings initiated after December 31, [1975] **1977**.

HE 113-199 Reserved for future use.

HE 202-206, 209-214, 216-218, 222 Contested case hearings.

HE 202 Definitions.

[(a) Commencement. Commencement means service of an order for hearing upon any party.]

[(b)] **A.** Hearing examiner. The Hearing Examiner means the person or persons [appointed] **assigned** by the Chief Hearing Examiner pursuant to Minn. Stat. § 15.052, subd. 3, to hear the contested case.

[(c)] **B.** Party. Party means each person named [or admitted] as a party or [properly seeking and entitled as of right to be admitted as a party] **persons granted permission to intervene pursuant to HE 210.** The term "party" shall include the agency, except when the agency participates in the contested case in a neutral or quasi-judicial capacity only.

[(d)] **C.** Person. Person means any individual, partnership, corporation, joint stock company, unincorporated association or society, municipal corporation, or any government or governmental subdivision, unit or agency other than a court of law.

[(e)] **D.** Service; serve. Service or serve means personal service or, unless otherwise provided by law, service by First Class United States mail, postage prepaid and addressed to the party at his last known address. An affidavit of service shall be made by the person making such service. Service by mail is complete upon the placing of the item to be served in the mail. **Agencies of the State of Minnesota may also serve by depositing the item to be served with Central Mailing Section, Publications Division, Department of Administration.**

HE 203 Hearing examiners.

[(a)] **A.** Request for [Appointment] **Assignment.** Any agency desiring to order a contested case hearing shall first file with the Chief Hearing Examiner a request for [appointment] **assignment** of a Hearing Examiner together with [a proposed] **the notice of and** order for hearing **proposed to be issued which shall include** [including] a proposed time, date and place for the hearing. **The request shall include a statement by the agency that the facility where the hearing is to be conducted is free of mobility barriers in accordance with Executive Order No. 148.**

[(b)] **B.** [Appointment] **Assignment.** Within ten days of receipt of a request pursuant to HE 203 [(a)] **A.**, the Chief Hearing Examiner shall [appoint] **assign** a Hearing Examiner to hear the case and the Hearing Examiner shall advise the agency as to the location at which and time during which a hearing should be held so as to allow for participation by all affected persons.

[(c)] **C.** Duties. Consistent with law the Hearing Examiner shall perform the following duties:

[(1)] **1.** Grant or deny a demand for a more definite statement of charges.

[(2)] **2.** Grant or deny requests for discovery or for the taking of depositions.

[(3)] **3.** Receive and act upon requests for subpoenas [where appropriate].

[(4)] **4.** Hear and rule on motions.

[(5)] **5.** Preside at the contested case hearing.

[(6)] **6.** Administer oaths and affirmations.

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[(7)] **7.** Grant or deny continuances.

[(8)] **8.** Examine witnesses **and call witnesses** where he deems it necessary to make a complete record.

[(9)] **9.** Prepare findings of fact, conclusions and recommendations.

[(10)] **10.** Make preliminary, interlocutory or other orders as he deems appropriate.

[(11)] **11.** Do all things necessary and proper to the performance of the foregoing.

[(12)] **12.** In his discretion, perform such other duties as may be delegated to him by the agency ordering the hearing.

HE 204 Commencement of a contested case. A contested case is commenced, subsequent to the [appointment] **assignment** of a Hearing Examiner, by the issuance of a[n] **notice of and** order for hearing by the agency.

[(a)] **A.** The order. **Unless otherwise provided by law,** a[n] **notice of and** order for hearing, **which shall be a single document**, shall be served upon all parties and shall contain, among other things, the following:

[(1)] **1.** The time, date and place for the hearing.

[(2)] **2.** Name and address and telephone number of the Hearing Examiner.

[(3)] **3.** A citation to the agency's statutory authority to hold the hearing and to take the action proposed.

[(4)] **4.** A statement of the allegations or issues to be determined together with a citation to the relevant statutes or rules.

[(5)] **5.** Notification of the right of the parties to be represented by legal counsel **or by a person other than an attorney, if that person possesses special qualifications pertinent to the subject matter of the hearing.**

[(6)] **6.** A citation to these rules and to any applicable procedural rules of the agency.

[(7)] **7.** A statement advising the parties of the name of the agency official or member of the Attorney General's staff to be contacted to discuss informal disposition pursuant to HE 207 or discovery pursuant to HE 214.

[(8)] **8. In cases wherein the agency is a party,** [A] **a** statement advising the parties that a Notice of Appearance must be filed with the Hearing Examiner [at least ten days prior to the hearing] **within 20 days of the date of service of the Notice of and Order for Hearing** if a party intends to appear at the hearing unless the hearing date is less than 20 days from the commencement of the contested case.

[(9)] **9.** A statement advising the parties that failure to appear at the hearing may result in the allegations of the **notice of and** order for hearing being taken as true, **or the issues set out being deemed proved, and a statement which explains the possible results of the allegations being taken as true or the issues proved.**

[(b)] **B.** Service. **Unless otherwise provided by law,** [T]the **notice of and** order for hearing shall be served not less than 30 days prior to the hearing. [unless otherwise provided by law, or] **A shorter time may be allowed, if not contrary to statutory requirements,** where it can be shown to the Chief Hearing Examiner that a shorter time is required in the public interest **and that no interested person will be adversely affected** [without substantial adverse effect to the parties, and a copy shall be served upon the Hearing Examiner appointed to hear the case].

[(c) Notice. The Notice of Appearance form provided for in HE 205 shall be included with each order for hearing served by the agency.]

[(d) Publication. Where the agency participates in the hearing in a neutral or quasi-judicial capacity, the order for hearing shall be published as required by law or as ordered by the agency and copies of the order for hearing may be mailed by the agency to persons known to have a direct interest.]

[(3)] **C.** Amendments. At any time prior to the close of the hearing the agency may file and serve an amended **notice of and** order for hearing, provided that, should the amended **notice and** order raise new issues or allegations, the parties shall have a reasonable time to prepare to meet the new issues or allegations if requested.

D. Alternatives. With the concurrence of the Chief Hearing Examiner, an agency may substitute other documents and procedures for the notice of and order for hearing provided that the documents and procedures inform actual and potential parties of the information contained in HE 204 A. 1-9 above.

HE 205 Notice of appearance. Each party intending to appear at the contested case hearing shall file with the Hearing Examiner a Notice of Appearance which shall advise the Hearing Examiner of the party's intent to appear and shall indicate the title of the case, the agency ordering the hearing, the party's current address and telephone number and the name, office address, and telephone number of the party's attorney. The Notice of Appearance shall be filed with the Hearing Examiner [at least 10 days prior to the hearing] **within 20 days of the date of service of the Notice of and**

Order for Hearing, except that, where the hearing date is less than 20 days from the commencement of the contested case, the Notice of Appearance shall not be necessary. The failure to file a Notice may, in the discretion of the Hearing Examiner, result in a continuance of the hearing if the party failing to file appears at the hearing. **The form shall be included with the Notice of and Order for Hearing in all applicable cases.**

HE 206 Right to counsel. Any party may be represented by legal counsel throughout the proceedings in a contested case before an agency **or by a person other than an attorney, if that person possesses special qualifications pertinent to the subject matter of the hearing.**

HE 209 Time.

[(a)] **A.** Computation of time. In computing any period of time prescribed by these rules or the procedural rules of any agency, the day of the last act, event, or default from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, Sunday or a legal holiday. **When the period of time prescribed or allowed is less than 7 days, intermediate Saturdays, Sundays, and legal holidays shall be excluded in the computation.**

[(b)] **B.** Additional time after service by mail. Whenever a party has the right or is required to do some act or take some action within a prescribed period after the service of a notice or other paper upon him, or whenever such service is required to be made within a prescribed period before a specified event, and the notice or paper is served by mail, three days shall be added to the prescribed period.

HE 210 Intervention.

[(a)] **A.** Petition. Any person desiring to intervene in a contested case as a party shall submit a timely petition to intervene to the Hearing Examiner and shall serve the petition upon all existing parties **and the agency if the agency is not a party**. Timeliness will be determined by the Hearing Examiner in each case based on circumstances at the time of filing. The petition shall show how the petitioner's legal rights, duties, or privileges may be determined or affected by the contested case, and shall set forth the grounds and purposes for which intervention is sought and shall indicate petitioner's statutory right to intervene if one should exist. The agency may, with the consent of the Chief Hearing Examiner, and where good reason appears therefor, specify in the Notice of and Order for Hearing the final date upon which a petition for intervention may be submitted to the Hearing Examiner.

[(b)] **B.** Objection. Any party may object to the petition for intervention by filing a Notice of Objection with the Hearing Examiner within 7 days of service of the petition. The Notice shall state the party's reasons for objection and shall be served upon all parties and the person petitioning to intervene **and the agency if the agency is not a party.**

[(c)] **C.** Order. The Hearing Examiner shall allow intervention upon a proper showing pursuant to HE 210 [(a)] **A.** unless the Hearing Examiner finds that the petitioner's interest is adequately represented by one or more parties participating in the case. **In the event the Hearing Examiner finds that one or more petitions are similar, he may allow the petitions to be consolidated as one, allowing all such petitioners to intervene but only as one party.** [The order allowing intervention shall specify the extent of participation permitted the intervenor and shall state the Hearing Examiner's reasons therefor. An intervenor may be allowed to:

(1) File a written brief without acquiring the status of a party; or

(2) File a written brief, introduce evidence and cross-examine witnesses at the hearing, but without acquiring the status of a party; or

(3) Intervene as a party with all the rights of a party.]

[(d)] **D.** Agency in a neutral capacity. Where the agency participates in the hearing in a neutral or quasi-judicial capacity, [then:

(1) Any person intending to object to or protest an application or petition or other request of a party may petition to intervene under this rule and, in addition to the requirements of HE 210(a), shall set forth the grounds of the objection or protest.

(2) Any person desiring to claim the same right or privilege as that requested by an applicant, petitioner or similar party may petition to intervene under this rule, and in addition to the requirements of HE 210(a), he shall set forth the grounds of his competing claim.]

[(3)] [T]the agency staff, or a portion of the agency staff, may petition to intervene under the rule.

[(e)] **E.** Participation by the public. [Regardless of the status of the agency,] [t]The Hearing Examiner, may, in the absence of a petition to intervene, nevertheless hear the

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testimony, **with or without benefit of oath**, and receive exhibits from any person at the hearing, or allow a person to note his appearance, **or allow a person to question witnesses,** but no person shall become, or be deemed to have become, a party by reason of such participation. **Persons allowed to participate as above may be questioned by parties to the proceeding.**

HE 211 Consolidation.

[(a)] **A.** Authority. Whenever, before hearing on any contested case, the Chief Hearing Examiner, either on his own motion or on the motion of the Hearing Examiner assigned to the case, or upon petition by any party, determines (a) that separate contested cases present substantially the same issues of fact and law; (b) that a holding in one case would affect the rights of parties in another case; and (c) the consolidation would not substantially prejudice any party, the Hearing Examiner may order such cases consolidated for a single hearing on the merits. Notwithstanding the requirements of this rule, the parties may stipulate and agree to such consolidation.

[(b)] **B.** Notice of order. Following an order for consolidation the Hearing Examiner shall forthwith serve on all parties a copy of the order for consolidation. The order shall contain, among other things:

[(1)] **1.** A description of the cases for consolidation.

[(2)] **2.** The reasons for consolidation.

[(3)] **3.** Notification of a consolidated prehearing conference if one has been requested.

[(c)] **C.** Objection to consolidation.

[(1)] **1.** Petition for severance. Any party may object to consolidation by filing with the Hearing Examiner, **and serving upon all parties and the agency if it is not a party,** at least 7 days prior to the hearing in the case a petition for severance from consolidation, setting forth petitioner's name and address, the title of his case prior to consolidation, and the reasons for his petition.

[(2)] **2.** Determination. If the Hearing Examiner finds that consolidation would prejudice petitioner, he may order such severance or other relief as he deems necessary.

HE 212 Disqualification. The Hearing Examiner shall withdraw from participation in a contested case at any time if he deems himself disqualified for any reason. Upon the filing in good faith by a party of an affidavit of prejudice the Chief Hearing Examiner shall, **absent objection from another party, reassign the case to another Hearing Examiner. Any party may object to the affidavit of prejudice. In such instance, the Chief Hearing Examiner shall determine the matter as a part of the record. All affidavits of prejudice and objections thereto shall be served on all parties and the agency if the agency is not a party, and shall state with specificity the reasons for the affidavit or the objections thereto.**

In the event another affidavit of prejudice is filed by any party, the Chief Hearing Examiner shall determine the matter as a part of the record provided the affidavit shall be filed no later than 15 days prior to the date set for hearing.

HE 213 Prehearing [Conference] **procedures**.

A. Prehearing conference.

[(a)] **1.** Purpose. The purpose of the prehearing conference is to simplify the issues to be determined, to consider amendment of the agency's order if necessary, to obtain stipulations in regard to foundation for testimony or exhibits, to consider the proposed witnesses for each party, to consider such other matters that may be necessary or advisable and, if possible, to reach a settlement without the necessity for further hearing.

[(b) **2.** Procedure. Upon the request of any party or upon his own motion, the Hearing Examiner may, in his discretion, hold a prehearing conference prior to each contested case hearing. The Hearing Examiner may require the parties to file a prehearing statement prior to the prehearing conference which shall contain such items as the Hearing Examiner deems necessary to promote a useful prehearing conference. A prehearing conference shall be an informal proceeding conducted expeditiously by the Hearing Examiner. Agreements on the simplification of issues, amendments, stipulations, or other matters may be entered on the record or may be made the subject of an order by the Hearing Examiner. Any final settlement shall be set forth in a settlement agreement or consent order and made a part of the record.

B. Motions. Any application to the Hearing Examiner for an order shall be by motion which, unless made during a hearing, shall be made in writing, shall state with particularity the grounds therefor, and shall set forth the relief or order sought. Motions provided in these rules are motions requiring a written notice to all parties and to the agency if the agency is not a party, and may require a hearing before the order can be issued.

HE 214 Discovery.

[(a)] **A.** Demand. Each party shall, within 10 days of a demand by another party, disclose the following:

[(1)] **1.** The names and addresses of all witnesses that the party intends to call at the hearing. All witnesses un-

known at the time of said disclosure shall be disclosed as soon as they become known.

[(2)] **2.** Any relevant written or recorded statements made by a party or by witnesses on behalf of a party. The demanding party shall be permitted to inspect and reproduce any such statements. Any party unreasonably failing upon demand to make the disclosure required by this rule may, in the discretion of the Hearing Examiner, be foreclosed from presenting any evidence at the hearing through witnesses not disclosed or through witnesses whose statements are not disclosed.

[(b)] **B.** Requests for admissions. A party may serve upon any other party a written request for the admission of relevant facts or opinions, or of the application of law to relevant facts or opinions, including the genuineness of any documents. The request must be served at least 15 days prior to the hearing and it shall be answered in writing by the party to whom the request is directed within 10 days of receipt of the request. The written answer shall either admit or deny the truth of the matters contained in the request or shall make a specific objection thereto. Failure to make a written answer shall result in the subject matter of the request being deemed admitted.

[(c)] **C.** Motion to hearing examiner. Upon the motion of a party, the Hearing Examiner may order discovery of any other relevant material or information, provided that privileged work product (e.g. that of attorneys, investigators, etc.) shall not be discoverable. **The Hearing Examiner shall also recognize all other privileged information or communications which are recognized at law. Upon proper motion made to the Hearing Examiner, any other means of discovery available pursuant to the Rules of Civil Procedure for the District Courts of the State of Minnesota may be allowed provided that such requests can be shown to be needed for the proper presentation of a party's case and not for purposes of delay.** Upon the failure of a party to reasonably comply with an order of the Hearing Examiner made pursuant to this rule, the Hearing Examiner may make a further order as follows:

[(1)] **1.** An order that the subject matter of the order for discovery or any other relevant facts shall be taken as established for the purposes of the case in accordance with the claim of the party requesting the order.

[(2)] **2.** An order refusing to allow the party failing to comply to support or oppose designated claims or defenses, or prohibiting him from introducing designated matters in evidence.

D. Proprietary information. Nothing in these rules shall require the revealing of proprietary information or trade secrets. When a party is asked to reveal such information, he shall bring the matter to the attention of the Hearing Examiner, who shall make such protective orders as are reasonable and necessary.

HE 216 Subpoenas. **Following the commencement of a contested case pursuant to these rules, only subpoenas issued by the Chief Hearing Examiner shall be used during the course of the administrative proceeding.** Requests for subpoenas for the attendance of witnesses or the production of documents shall be made in writing to the Hearing Examiner, **and copies served upon all parties and the agency if the agency is not a party,** and shall contain a brief statement demonstrating the potential relevance of the testimony or evidence sought and shall identify any documents sought with specificity, **and shall name all persons to be subpoenaed.** [Requests for subpoenas may be made only in cases wherein the agency involved has statutory subpoena power.]

[(a)] **A.** Service of subpoenas.

[(1)] **1.** A subpoena shall be served in the manner provided by the Rules of Civil Procedure for the District Courts of the State of Minnesota unless otherwise provided by law.

[(2)] **2.** The cost of service, fees, and expenses of any witnesses subpoenaed shall be paid by the party at whose request the witness appears.

[(3)] **3.** The person serving the subpoena shall make proof of service by filing the subpoena with the Hearing Examiner, together with his affidavit of service.

[(b)] **b.** Motion to quash. Upon the motion made promptly, and in any event at or before the time specified in the subpoena for compliance therewith, the Hearing Examiner may quash or modify the subpoena if he finds that it is unreasonable or oppressive.

HE 217 The hearing.

[(b)] **B.** Witnesses. Any party may be a witness or may present witnesses on his behalf at the hearing. All oral testimony at the hearing shall be under oath or affirmation **subject only to the provisions of HE 210 E. Testimony offered not subject to oath or affirmation shall be given such weight as the Hearing Examiner deems appropriate.** At the request of a party or upon his own motion the

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Hearing Examiner may exclude witnesses from the hearing room so that they cannot hear the testimony of other witnesses.

[(c)] **C.** Rules of evidence.

7. Offer of proof. If an objection to a question propounded to a witness is sustained, the examining person may make a specific offer of what he expects to prove by the answer of the witness. Upon request, the Examiner shall take the evidence in full, unless it clearly appears that the evidence is not admissible on any ground or that the witness is privileged.

[(d)] **D.** The record.

[(1)] **1.** [Agency prepares record.] The [agency] **Hearing Examiner** shall prepare and maintain the official record in each contested case **until the issuance of his final report, at which time the record shall be sent to the agency.**

[(2)] **2.** What the record shall contain. The record in a contested case shall contain:

[(aa)] **a.** All pleadings, motions and orders;

[(bb)] **b.** Evidence received or considered;

[(cc)] **c.** Offers of proof, objections and rulings thereon;

[(dd)] **d.** The Hearing Examiner's findings of fact, conclusions and recommendations;

[(ee)] **e.** All memoranda or data submitted by any party in connection with the case[.]**;**

f. The transcript of the hearing, if one was prepared.

[(3)] **3.** The transcript.

[(aa) Reporter. A court reporter from the Office of Hearing Examiners shall keep a record at each contested case hearing unless the Chief Hearing Examiner determines that the use of an audio magnetic recording device is more appropriate.]

[(bb) Transcription.] The verbatim record shall be transcribed if requested by [a party] **any person** or in the discretion of the Chief Hearing Examiner. If a transcription is made, the Chief Hearing Examiner [may] **shall** require the requesting [party] **person** and other [parties] **persons** who request copies of the transcript to pay a reasonable charge therefor. The charge shall be set by the Chief Hearing Examiner and all monies received for transcripts shall be payable to the State Treasurer and shall be deposited in the State Office of Hearing Examiners account in the State Treasury.

[(f)] **F.** Motions [of] **to** the agency. No Motions shall be made directly to or be decided by the agency subsequent to the [appointment] **assignment** of a Hearing Examiner and prior to the completion and filing of the Hearing Examiner's report unless the motion is certified to the agency by the Hearing Examiner. Uncertified motions shall be made to the Hearing Examiner and considered by the agency in its consideration of the record as a whole subsequent to the filing of the Hearing Examiner's report.

Any party may request that a motion decided adversely to that party by the Hearing Examiner during the course of the hearing be certified by the Hearing Examiner to the agency. Such request must be made at the time the Hearing Examiner rules on the motion. In deciding what motions should be certified, the Examiner shall consider the following:

1. Whether the motion involves a controlling question of law as to which there is substantial ground for a difference of opinion; and

2. Whether a final determination by the agency on the motion would materially advance the ultimate termination of the hearing.

[(g)] **G.** Hearing procedure.

[(2)] **2.** Conduct of the hearing. **Unless the Hearing Examiner determines that the public interest will be equally served otherwise,** [T]the hearing shall be conducted substantially in the following manner:

[(aa)] **a.** After opening the hearing, the Hearing Examiner shall indicate the procedural rules for the hearing including the following:

[(i)] **(1)** All parties may present evidence and argument with respect to the issues and cross-examine witnesses. **At the discretion of the Hearing Examiner, a party, by its attorney or by any representative of that party, or by any combination of such persons, may cross-examine each witness, provided that only one person shall cross-examine each witness on behalf of a party on any one subject matter of testimony. At the request of the party being cross-examined, the Hearing Examiner may make such rulings as are necessary to prevent repetitive or irrelevant questioning and to expedite the cross-examination to the extent consistent with disclosure of all relevant testimony and information.**

[(hh)] **h.** The record of the hearing shall be closed

upon receipt of the final written memorandum, **transcript, if any, or late filed exhibits, whichever occurs latest.**

HE 218 The decision.

[(a)] **A.** Basis for determination.

[(1)] **1.** The record. No factual information or evidence, except tax returns and tax reports, which is not a part of the record shall be considered by the Hearing Examiner or the agency in the determination of a contested case.

[(2)] **2.** Administrative notice. The Hearing Examiner and agency may take administrative notice of general, technical or scientific facts within their specialized knowledge in conformance with the requirements of Minn. Stat. § 15.0419, subd. 4.

[(b)] **B.** Hearing examiner's report. Following the close of the record [and the completion of the transcript,] the Hearing Examiner shall make his report pursuant to Minn. Stat. § 15.052, subd. 3, and, upon completion, a copy of said report shall be served upon all parties by regular mail **or by depositing it with Central Mailing Section, Publications Division, Department of Administration.**

[(c)] **C.** Agency decision. Following receipt of the Hearing Examiners' report, the agency shall proceed to make its final decision in accordance with Minn. Stat. § 15.0421 and Minn. Stat. § 15.0422, **and shall send a copy of such final order to the Office of Hearing Examiners.**

HE 222 Effective date. These rules shall be effective for all contested cases commenced after December 31, [1975] **1977.**

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OFFICIAL NOTICES

Department of Health

Notice of Intent to Solicit Outside Opinion on Rules Governing Water Well Contractor Licensing and Public Water Supply Construction

Notice is hereby given, pursuant to the provisions of Minn. Stat. § 15.0412 subd. 6 (1976) the the Commissioner of Health will propose the amendment of existing rules and the adoption of new rules.

All interested parties desiring to submit data or views relating to the proposed amendment or adoption of the rules noted below should address their comments (either written or oral) to the Minnesota Department of Health, Division of Environmental Health, 717 Delaware Street S.E., Minneapolis, Minnesota 55440 by writing or calling the persons designated. Evidence submitted for consideration should be pertinent to the matter at hand. Any material received by the Department of Health will become part of the hearing record.

1. Proposed amendments to Minnesota Water Well Contractors Code relating to licensing of drillers.

Contact: Edwin H. Ross
Phone: 612/296-5339

2. Proposed adoption of rules relating to Public Water Supply Construction.

Contact: Paul B. Johnson
Phone: 612/296-5331

Department of Human Rights

Notice of Settlement Agreements Made between August 12, 1977 and August 29, 1977

In addition to specific remedies, standard agreements reached prior to a hearing contain the following two stipulations:

1. The agreement does not constitute an admission by the respondent of a violation of Minn. Stat. ch. 363.

2. The respondent agrees to abide by the provisions of Minn. Stat. ch. 363.

Department of Human Rights, Complainant, vs. Whirlpool Corporation, Respondent, E1707.

Charge.

A person (hereinafter "charging party") filed a charge alleging that Whirlpool Corporation (hereinafter "respondent") had discriminated against him because of a disability. The charging party alleged that the respondent had refused to employ him because of a disability from which he had fully recovered. Following an investigation, the Commissioner of Human Rights found that there was reason to credit the charging party's allegation.

Settlement.

The charging party and the respondent agreed to voluntarily settle the matter in the following manner:

1. The respondent agreed to pay the charging party the sum of $850.00 on the date of the execution of the agreement.

2. The charging party waived any right or claim to employment with Whirlpool Corporation.

Department of Human Rights, Complainant, vs. WCCO-TV, Respondent, E2144.

Charge.

A person (hereinafter "charging party") alleged that his employer, WCCO-TV (hereinafter "respondent"), had discriminated against him by denying him a promotion when vacancies occurred because of his race. Following an investigation, the Commissioner of Human Rights found that there was reason to credit the charging party's allegation.

Settlement.

The charging party and the respondent agreed to voluntarily settle the matter in the following manner:

1. The respondent agreed to pay the charging party the sum of $1,000.00 in full settlement for the charge filed with the Human Rights Department.

2. The respondent agreed to present for inspection to the Minnesota Human Rights Department a copy of the last Affirmative Action Policy that it submitted to the Federal Communications Commission.

Department of Human Rights, Complainant, vs. F. W. Woolworth Co., Respondent, E3370.

Charge.

An organization (hereinafter "charging party") alleged that F. W. Woolworth Co. (hereinafter "respondent") was discriminating against applicants for employment by requiring applicants to furnish information that pertained

to their marital status. Following an investigation, the Commissioner of Human Rights found that there was reason to credit the allegation of unfair discriminatory practice.

Settlement.

The charging party and the respondent agreed to settle the matter as follows:

1. The respondent agreed to discontinue use of its application form.

2. The respondent agreed to implement use of an application form which was reviewed and approved by the Department of Human Rights.

Department of Human Rights, Complainant, vs. Minnesota Department of Employment Services, Respondent, E3038.

Charge.

A person (hereinafter "charging party") filed a charge alleging that his employer, the Minnesota Department of Employment Services (hereinafter "respondent"), had discriminated against him because of his race by refusing to consider him for a merit increase. Following an investigation, the Commissioner of Human Rights found that there was reason to believe that an unfair discriminatory practice had occurred.

Settlement.

The charging party and the respondent agreed to settle the matter in the following manner:

1. The respondent agreed to pay to the charging party the sum of $179.00 plus interest within 14 days of the execution of the agreement.

2. The respondent agreed to file with the Commissioner of Human Rights and with the respondent's Affirmative Action Officer, copies of the procedure and the criteria to be used in granting achievement awards.

3. The Commissioner and the Department may review compliance with the agreement and with the procedures and criteria used to grant achievement awards.

4. The Affirmative Action Officer of the respondent shall monitor, during the next two (2) fiscal years, compliance with the agreement and shall report to the Commissioner of Human Rights any deviation from the procedures and criteria used to grant achievement awards.

Department of Human Rights, Complainant, vs. Department of Manpower Services, Respondent, E1641.

Charge.

A person (hereinafter "charging party") alleged that she had been discriminated against because of her race by the Minnesota Department of Manpower Services (hereinafter "respondent"). The charging party alleged that the respondent had refused to rehire her when she reapplied for a job she had held for two years. The Commissioner of Human Rights found probable cause to credit the charging party's allegations.

Settlement.

The charging party and the respondent agreed to settle the matter in the following manner:

1. The respondent agreed to pay to the charging party the sum of $2,000.00.

Department of Human Rights, Complainant, vs. United States Steel, Respondent, E1499.

Charge.

A person (hereinafter "charging party") filed a charge alleging that United States Steel, Minntac Plant (hereinafter "respondent"), had refused to hire her as a general laborer because of her sex. Following an investigation, the Commissioner of Human Rights found that there was probable cause to believe the charging party's allegations.

Settlement.

The charging party and the respondent agreed to settle the matter as follows:

1. The respondent agreed to pay to the charging party the sum of $1,700.00 in settlement of the charge.

St. Croix Ambulance Service

Notice of Application for License

On August 16, 1977, St. Croix Emergency Services Ambulance filed application with Warren R. Lawson, M.D., Commissioner of Health, for a license to operate a (an) emergency/nonemergency ambulance service with a base of operation in St. Croix Falls, Wisconsin. This notice is made pursuant to Minn. Stat. § 144.802 (Supp..1977). Please be advised that Subdivision 2 of that statute states, in part: The Commissioner may grant or deny the license 30 days after notice of filing has been fully published. If the Commissioner receives a written objection to the application from any person within 20 days of the notice having been fully published, the license shall be granted or denied only after a contested case hearing has been conducted on the application. The Commissioner may elect to hold a contested case hearing if no objections to the application are received. If a timely objection is not recieved, the Commissioner may

grant or deny the requested license based upon the information contained in the license application. If licensure is denied without hearing, the applicant, within 30 days after receiving notice of denial, may request and shall be granted a contested case hearing upon the application, at which hearing all issues will be heard de novo. Any objections to this service, pursuant to Minn. Stat. § 144.802 (Supp. 1977) may be made in writing to Warren R. Lawson, M.D., within the time period outlined by statute.

Water and Wastewater Operator Certification Council

Notice of Intent to Solicit Outside Opinion on the Revision of an Existing Rule

Notice is hereby given, pursuant to the provisions of Minn. Stat. § 15.0412 subd. 6 (1976) that the Water and Wastewater Operator Certification Council will propose the revision of its existing rule.

All interested parties desiring to submit data or views relating to the proposed revision of WWOB 1 should address their comments (either written or oral) to Paul B. Johnson, Secretary, Minnesota Department of Health, Division of Environmental Health, 717 Delaware Street S.E., Minneapolis, Minnesota 55440, phone: (612) 296-5331. Evidence submitted for consideration should be pertinent to the matter at hand. Any material received by the council will become part of the hearing record.

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