12/17/90

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of Proposed Rules
of the Department of Human Services
Governing Eligibility to Receive
Payment as a Provider of Rehabilitation
Agency Services, Rehabilitative and
Therapeutic Services in the Medical
Assistance Program, Minnesota Rules,
Parts 9505.0385, 9505.0386, 9505.0390
to 9505.0392, and 9505.0410 to 9505.0412

STATEMENT OF NEED
REASONABLENESS

Minnesota Rules, parts 9505.0385, 9505.0386, 9505.0390 to 9505.0392, and 9505.0410 to 9505.0412 are proposed by the Department of Human Services as the standards to receive payment as a provider of rehabilitative and therapeutic services to medical assistance recipients. If they are adopted they will supersede the present medical assistance rules, part 9500.1070, subparts 12 to 15 which were adopted in 1978 and 1979. The proposed rules will clarify requirements about the provision of rehabilitative and therapeutic services under medical assistance and update the requirements to be consistent with applicable federal and state laws and regulations. The proposed rules, if adopted, also will make minor amendments to parts 9505.0290 and 9505.0295 which were adopted in 1988.

The medical assistance program in Minnesota is the joint federal-state program that implements the provisions of Title XIX of the Social Security Act by providing for the medical needs of low income or disabled persons and families of dependent children. (See United States Code, title 42, section 1396a, hereafter abbreviated as 42 U.S.C.1396a.) Code of Federal

Regulations, Title 42, section 431.10, (hereafter abbreviated as 42 CFR 431.10), requires a state to designate a single state agency to supervise the administration of a state's medical assistance program. The Department of Human Services has been so designated in Minnesota Statutes, section 256B.04, subdivision 1. Furthermore, 42 CFR 431.10 requires the state agency so designated to make rules and regulations that it will follow in administering the State Plan. The State Plan is the comprehensive written commitment of the department to administer and supervise the medical assistance program according to federal requirements. Correspondingly, Minnesota Statutes, section 256B.04, subdivision 2 requires the Commissioner of Human Services to establish "uniform rules and regulations, not inconsistent with law" to ensure that the medical assistance program will be carried out in an efficient, economic, and impartial manner. Further justification for the rules is found in Minnesota Statutes, section 256B.04, subdivision 4 which states, in part, that the department shall cooperate with the federal government "in any reasonable manner as may be necessary to qualify for federal aid in connection with the medical assistance program..." Thus, authority for the rules is derived from both federal and state law. It is through proposing these rules, and the holding of a public hearing thereon, that the public, all interested parties, and all persons affected by the rules are afforded the opportunity to comment upon the procedures and standards the department uses to carry out the mandates.

Rules to administer Minnesota's medical assistance program are necessary

because they set uniform standards which can be objectively applied. Furthermore, these rules inform the public and affected persons of the medical assistance requirements that a provider must meet to receive medical assistance payment for health service to a recipient.

Parts 9505.0385, 9505.0386, 9505.0390 to 9505.0392, and 9505.0410 to 9505.0412 set forth the specific rehabilitative and therapeutic services that are eligible for payment under the Minnesota medical assistance program. The services must be consistent with federal regulations, Minnesota Statutes, and previously promulgated rules (but not rules proposed to be repealed or modified) governing the administration of the Minnesota Medical Assistance program.

42 CFR, part 440, "interprets section 1905 (a) of the (Social Security Act) which established the services included in the term "medical assistance", sections 1905 (c), (d), (f)-(i), (l), and (m) which define some of those services, and section 1915 (c) which defines as "medical assistance" certain home and community-based services provided under waivers under that section. Services so identified include those a state must provide and the optional services a state may provide to receive federal financial participation. Minnesota Statutes, chapter 256B, established a statewide program of medical assistance and specifies in section 256B.0625 those mandatory and optional services that are eligible for medical assistance payment in Minnesota. As required in Minnesota Statutes, section 256B.04, subdivisions 2 and 12, the proposed rule parts establish limits on the types and frequency of rehabilitative and therapeutic services to an individual recipient that are eligible for medical assistance payment. 42 CFR 440.230 (d) permits the state to place appropriate limits on a service based on criteria related to medical necessity or utilization control procedures. Furthermore, 42 CFR 440.230 (b) requires each service to be "sufficient in amount, duration, and scope to achieve its purpose." Additionally, 42 CFR 440.240 (b) requires comparability of service for all recipients within a recipient group, that is a categorically needy group or a covered medically needy group.

The department adopted the present rules related to covered rehabilitative and therapeutic services in 1978 and amended the present rules slightly in 1979. Rules governing the administration of the medical assistance program and setting forth standards for other covered services were heard at hearings in April 1987 and April 1989. As a result of those hearings parts 9505.0170 to 9505.0475 were promulgated and are now in effect. The proposed parts related to standards for rehabilitative and therapeutic services, if adopted, will replace the remainder of the rule adopted in 1978 and 1979 and will provide minor modifications of parts 9505.0290 and 9505.0295 which were promulgated in 1987.

Rehabilitative and therapeutic services are currently provided by several separate provider types in the medical assistance program. Provider types affected by these rules include physical therapists, occupational therapists, audiologists, speech-language pathologists, home health agencies that provide rehabilitative and therapeutic services, rehabilitation agencies, comprehensive outpatient rehabilitation facilities, and long-term care facilities. In developing these proposed rules, the department was assisted by an advisory committee comprised of persons from the various provider types. A list of the committee members is attached as an appendix. Additionally, the department has obtained comment and advice from providers and recipients who are concerned about specific rule provisions affecting them. A list of these persons and the rule parts on which their input was sought is also attached.

In Minnesota, fee for service payments for rehabilitative and therapeutic services under medical assistance totalled approximately 20 million dollars of the 1.2 billion dollars paid in FY 1989 by the medical assistance program.

Additionally, medical assistance reimbursement of the rehabilitative nursing services or care which long term care facilities must provide to their residents as a condition of licensure is included in the long-term care per diem payments under parts 9549.0010 to 9549.0080 and 9553.0010 to 9553.0080.

Small business requirements

In preparing these rules, the Department considered the requirements of Minnesota Statutes, section 14.115 in regard to small businesses but believed that these rules come within the exemption given in section 14.115, subdivision 7 (c) because either the providers affected by this rule are providers of medical care or must comply with the standards as required under Minnesota Statutes, section 256B.04, subdivision 4.

Minnesota Statutes, section 146.01 states:

> The term "practicing healing" or "practice of healing" shall mean and include any person who shall in any manner for any fee, gift, compensation, or reward, or in expectation thereof, engage in, or hold out to the public as being engaged in, the practice of medicine or surgery, the practice of osteopathy, the practice of chiropractic, the practice of any legalized method of healing, or the diagnosis, analysis, treatment, correction, or cure of any disease, injury, defect, deformity, infirmity, ailment, or affliction of human beings, or any condition, or conditions incident to pregnancy or childbirth, or examination into the fact, condition, or cause of human health or disease, or who shall, for any fee, gift, compensation, or reward, or in expectation thereof, suggest, recommend, or prescribe any medicine or any form of treatment, correction, or cure thereof; also any person, or persons, individually or collectively, who maintains an office for the reception, examination, diagnosis, or treatment of any person for any disease, injury, defect, deformity, or infirmity of body or mind, or who attached the title of doctor, physician, surgeon, specialist, M.D., M.B., D.O., D.C., or any other word, abbreviation, or title to the person's name indicating, or designed to indicate, that the person is engaged in the practice of healing.

Thus a person "practicing healing" as defined above is considered to be involved in the practice of a health service that constitutes medical care.

The rehabilitation and therapeutic services covered under these rules are furnished by or under the supervision of providers of medical care or practicing healing as defined above. These services are physical therapy, occupational therapy, audiology, and speech-language pathology which are the components of restorative and specialized maintenance therapies needed to improve or maintain a person's functional status at a level consistent with the person's physical or mental limitations. These services are provided by therapists who are employed by or under contract to rehabilitation agencies or long-term care facilities or who, in the case of physical therapists, audiologists, and speech-language pathologists, are in private practice and are enrolled as medical assistance providers.

These rules will not affect the present responsibility of or reimbursement of long-term care facilities in regard to rehabilitative nursing services that long-term care facilities now provide and must continue to provide. These services are a condition of licensure for long-term care facilities and must be available to residents according their needs. Payment for these services is included within the per diem payment under medical assistance rules, parts 9549.0010 to 9549.0080 and 9553.0010 to 9553.0080.

In the event that these rules are not exempt under subdivision 7, the

department has considered the methods listed in subdivision 2 of section 14.115 for reducing the impact of the rule on small businesses. In considering these methods, the department was mindful of the need to comply with extensive federal and state requirements applicable to the medical assistance program. Medical assistance is a federal program established under Title XIX of the Social Security Act, 42 U.S.C 1396a, et seq.. Title XIX and its implementing regulations specify the program standards and limitations and reporting requirements with which a state must comply to obtain federal financial participation in paying the cost of the program. As stated above, Minnesota Statutes, section 256B.04, subdivision 4 requires the department to cooperate with the federal government "in any reasonable manner as may be necessary to qualify for federal aid in connection with the medical assistance program, including the making of such reports in such form and containing such information as the department of health, education, and welfare may, from time to time, require, and comply with such provisions as such department may, from time to time, find necessary to assure the correctness and verifications of such reports." Minnesota Statutes, section 256B.04, subdivision 2 requires the department to "make uniform rules, not inconsistent with law,....to the end that the medical assistance system may be uniformly administered throughout the state...." 42 CFR 431.50 (b)(1) requires a state medical assistance plan to provide that "the plan will be in operation statewide...under equitable standards for...administration that are mandatory throughout the State." Similarly, 42 CFR 433.33 requires the state medical assistance plan to assure that "individuals in similar circumstances will be equitably treated throughout the State." Thus, in addressing the concerns of Minnesota Statutes, section 14.115, subdivision 2, it is necessary and reasonable to review the requirements of federal law and regulations about program standards and reporting requirements.

Clause (a) of subdivision 2 requires consideration "of the establishment of less stringent compliance or reporting requirements for small businesses." 42 U.S.C. 1396 (a)(10)(B) requires the amount, duration, and scope of medical assistance to be the same for all persons receiving services under (10)(A). 42 U.S.C. 1396 (a)(19) requires medical assistance to provide services "in a manner consistent with simplicity of administration and the best interests of the recipients."

Clause (b) requires consideration of the "establishment of less stringent schedules or deadlines for compliance or reporting requirements for small business."

Clause (c) requires consideration of "the consolidation or simplification of compliance or reporting requirements for small businesses."

Because of their similarity the provisions of clauses (a) to (c) were considered together.

42 U.S.C. 1396 (a)(27) requires every person or institution providing medical assistance services to "keep such records as are necessary to fully disclose the extent of the services provided to" recipients and to furnish the state or the federal government any information required about payments for services. The federal statutory reporting requirements are minimum standards applicable to all providers of the same services and are not based on how much medical assistance business the provider does. These requirements are the minimum that department believes reasonably necessary to administer the medical assistance program in compliance with federal law.

Clause (d) requires consideration of "the establishment of performance standards for small businesses to replace design or operational standards required in the rule."

42 U.S.C. 1396 (a)(30) requires the state to assure that medical assistance payments are consistent with quality of care and to provide methods and procedures related to utilization review of the service toward this end. This requirement ties the medical assistance program to stringent compliance in regard to quality of care and does not permit the state to establish different levels of quality of care according to the size of the provider's business. Additionally the licensure standards with which the providers must

comply to obtain and retain their licenses set uniform standards applicable to all license holders without regard to the size of the license holder's business.
Clause (e) requires consideration of "the exemption of small businesses from any or all requirements of the rule."
42 U.S.C. 1396 (a)(10)(B) requires the amount, duration, and scope of medical assistance to be the same for all pesons receiving services under (10)A. Minnesota Statutes, section 256B.04, subdivision 2 requires the department to "make uniform rules...to the end that the medical assistance system may be uniformly administered throughout the state,..." The program and reporting standards in these rules have been accepted by the advisory committee as consistent with the prevailing standard among providers and representatives of users of home and community-based services. No members of the advisory committee suggested having more than a single set of program and reporting standards.

Thus, the Department believes it would be unreasonable and contrary to federal and state laws and regulations to modify the proposed rule to establish less stringent compliance or reporting standards, deadlines, simplified requirements, or exemptions in response to clauses (a) to (c) and (e) of Minnesota Statutes, section 14.115, subdivision 2. The Department also believes that the proposed rules, parts 9505.0385, 9505.0386, 9505.0390 to 9505.0392, and 9505.0410 to 9505.0412, do not contain design or operational standards as referenced in clause (d) of Minnesota Statutes, section 14.115, subdivision 2.

Finally to assure that small businesses are informed about these rules and have the opportunity to address their concerns in person, the department will notify concurrently with those on the agency list the associations representing the nursing homes and rehabilitation agencies, physical therapists, occupational therapists, speech-language pathologists, and audiologists. The notice to these associations will request them to include information about the proposed rules, the public hearing, and the opportunity to testify.

Rule Development Procedure

To develop the proposed rules, the Department followed the procedures mandated by the Administrative Procedures Act, the Office of Administrative Hearings, and internal department policies that ensure maximum opportunity for public input. Public input was sought through a Notice to Solicit Outside Opinion published in the State Register and a public advisory committee. The public advisory committee consisted of persons representing consumers, consumer advocates, long-term care facilities, rehabilitation agencies, and therapists' associations. See Appendix A for membership on the advisory committee.

Part 9505.0290 Home Health Agency Services
Subpart 3. Eligible providers.
Item D. This subpart specifies the home health agency services that are eligible to receive medical assistance payment. The amendment is a technical change that is necessary to delete the reference to the present rule provisions which will be repealed when the proposed rules become effective. The revision is reasonable because it clarifies the rule.

Part 9505.0295 Home Health Services
Subpart 2. Covered services.
Item F. This subpart specifies the types of services that are eligible for medical assistance payment when they are provided as a home health service. The amendment to item F is a technical change that is necessary to delete the

reference to the present rule provisions which will be repealed when the proposed rules become effective. The revision is reasonable because it clarifies the rule.

Part 9505.0385 Rehabilitation Agency Services
This part will supersede part 9500.1070, subpart 15. It clarifies and simplifies the language of the present rule. It also removes unnecessary language found in the present rule by crossreferencing to appropriate service provisions of parts 9505.0170 to 9505.0475, for example in referring to physician services under part 9505.0345 (see subpart 2, covered servcies.)
Subpart 1. Definitions. This subpart defines terms which are used in this part. Definitions are necessary to set a standard and clarify their meaning.
Item A. This item defines a term used in this proposed part that is not in the present rule. There are certain major disabling conditions that impair not only a person's physical condition but also the person's cognitive abilities. Examples of such disabling conditions are brain injuries incurred in accidents, strokes, Alzheimer's Disease, and chronic seizure disorders. A person with such a disabling condition may benefit from certain therapies that assist the person's adjustment to the impairment and help the person achieve a level of functioning consistent with the person's physical and mental limitations. Members of the advisory committee recommended that this definition acknowledge that a physical disability may result in cognitive impairment. The definition is reasonable because it responds to providers' concerns about making therapy available to persons who need the services.
Item B. This subpart defines the term "rehabilitation agency". It is a modification of the definition found in the present rule 9500.1070, subpart 15. The proposed definition deletes the service definitions in items A to H which are elsewhere in parts 9505.0170 to 9505.0475 and in proposed part 9505.0390. The proposed definition cites the federal regulations applicable to Medicare, 42 CFR 405.1702, paragraph i. These regulations set the standards for services eligible to receive Medicare and medical assistance payments. It is reasonable to require an agency to comply with federal standards because Minnesota Statutes, section 256B.04, subdivision 4 requires the state's compliance in any reasonable manner necessary to obtain federal financial participation. It retains the present rule's language that a rehabilitation agency provide social or vocational adjustment.

Subp. 2. Covered services. This subpart is necessary to specify the standard to obtain medical assistance payment for certain services provided by a rehabilitation agency. 42 CFR 405.1717 requires a physician order for outpatient physical therapy or speech pathology as a condition of participation in Medicare. 42 CFR 405.1717 (a) specifies the medical findings the physician must make available before, or at the time of, the start of the treatment. 42 CFR 405.1717 (b) specifies the contents of the required written plan of care, including the anticipated goals of the services. 42 CFR 405.1702 (i) specifies that the services must be part of "an integrated multidisciplinary program designed to upgrade the physical function" of the recipient. Thus requiring the services to be related to a program designed to improve or maintain the functional status of a recipient with a physical impairment is consistent with the federal regulations which must be met to obtain federal financial participation as required by Minnesota Statutes, section 256B.04, subdivision 4. Items A and B are necessary and reasonable because they assist the person to improve or maintain his or her functional status. They continue services required under the present rule but remove duplicative rule language. The proposed subpart adds the requirement that the services of a rehabilitation agency must be ordered for the recipient by a physician. The requirement is reasonable because it is consistent with the requirements of part 9505.0390 and assures that the same services under the medical assistance program will be implemented statewide in a uniform manner as required by Minnesota Statutes, section 256B.04, subdivision 2.

Subp. 3. **Eligibility as rehabilitation agency service; required site of service.** This subpart sets a standard for the site at which a rehabilitation agency provides its service in order to receive medical assistance payment for the service. The subpart is necessary to assure uniform administration of the medical assistance program as required by Minnesota Statutes, section 256B.04, subdivision 2 and to insure compliance with federal standards related to the site of service, a condition to obtain federal financial participation as required by Minnesota Statutes, section 256B.04, subdivision 4. 42 CFR 405.1723 to 405.1725 specify standards related to a rehabilitation agency's service site, infection control, and disaster preparedness which must be met as conditions of participation in Medicare. The Minnesota Department of Health as the designee of HCFA surveys sites at which Minnesota rehabilitation agencies provide services to determine whether the sites meet the Medicare standards. Sites that meet the standards receive Medicare certification and are eligible to receive Medicare payments for services to recipients. Some recipients are also Medicare eligible. It is reasonable to apply these site standards to services under the medical assistance program because use of federal standards not only assures at least a minimum level of quality but also maximizes the amount of federal financial participation through obtaining both Medicare funds and federal medical assistance dollars in meeting the cost of the services as required by Minnesota Statutes section 256B.04, subdivision 4. The present rule in part 9500.1070, subpart 15 requires a rehabilitation agency service to be provided "in accordance with applicable federal regulations, state law,....."
It is reasonable to require the agency to document that its site meets the standards of the Fire Marshal as the document is evidence of compliance. Not all rehabilitation agencies choose to provide services in a Medicare certified site. Therefore, it is necessary to clarify the standard for such agencies. The standards of the State Fire Marshal are designed to protect the safety of the persons occupying a public building such as a service site. Requiring the agency's service site to meet the standards of the State Fire Marshal is reasonable because the standards protect a person's safety while at the service site.

Rehabilitation agencies can and do provide care in a recipient's residence as an accommodation if the recipient cannot leave his or her residence. This residence is often a long-term care facility or the recipient's own home. Some of these recipients might have difficulty in arranging transportation to a site apart from their homes because they are unable to drive, their physical impairments preclude their use of commonly used means of transportation, or transportation is not available. Others of these recipients may be unable to leave their homes even if transportation is available. Providing the service needed by the recipient at the recipient's residence is reasonable as it is a means of ensuring access to services needed by these recipients. However it is preferable for the recipient to go to a certified site for care to assure the recipient's care is provided in a setting having standards for infection control and equipment. It should be noted that 42 CFR 405.1723 to 405.1725 specifying for Medicare purposes the standards of physical environment, infection control, and disaster preparedness that a rehabilitation agency must meet to receive Medicare reimbursement effectively prohibit payment for the provision of rehabilitative and therapeutic services in a neighbor's house. It also should be noted that the recipient who is able to leave his or her own home to go to a neighbor's home can reasonably be expected to be able to go to a certifed site.

Subp. 4. **Social and vocational adjustment services provided by rehabilitation agency.** This subpart clarifies the requirement of the present rule about the provision of social and vocational adjustment services provided by a rehabilitation agency. See part 9500.1070, subpart 15. Clarification is necessary to set the standard. This subpart is also

necessary to clarify that social and vocational adjustment services are not eligible for separate payment but must be provided as part of the covered services specified in these rules. 42 CFR 405.1702 specifies that a rehabilitation agency must provide at least "physical therapy and speech pathology services, and a rehabilitation program, which in addition to physical therapy or speech pathology services, includes social or vocational adjustment services to all patients in need of such services..." The social and vocational adjustment services must "evaluate the social or vocational factors involved in a patient's rehabilitation, counsel and advise on social or vocational problems arising from the patient's illness or injury," and make "appropriate referrals for required services." Adherence to this standard is a condition of participation in Medicare. As discussed in the SNR of subpart 2, it is reasonable to require the Medicare standard for rehabilitation agency services under the medical assistance program as its use assures at least a minimum level of quality and complies with Minnesota Statutes, section 256B.04, subdivision 4 by maximizing federal financial participation in paying for the service from another source for Medicare eligible persons, Medicare, which does not require a state match. Medicare certified rehabilitation agencies are designed to provide a package of services to their clients that includes social and vocational adjustment services. Medical assistance clients need this same package approach. It is reasonable to apply the same standard of service to both groups of clients because a single standard avoids a two tiered level of services to persons who have similar service needs. Finally, it should be noted that, although social and vocational adjustment services are not of themselves medically necessary services, they are a necessary adjunct to medically necessary services. Therefore it is reasonable to deny separate medical assistance payment because Minnesota Statutes, section 256B.04, subdivision 15 prohibits payment for services that are not medically necessary.

9505.0386 COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES.

Subpart 1. **Definition.** A "comprehensive outpatient rehabilitation agency" is a special case of a rehabilitation agency that is eligible to participate in the medical assistance program if it meets the conditions specified in 42 CFR 485, Subpart B. The term is not in the present rule but is used in the proposed rule. A definition of "comprehensive outpatient rehabilitation agency" or "(CORF)" is necessary to inform affected persons and set a standard. 42 CFR 485.51 defines a CORF in terms of its purpose and the requirements it must meet to be accepted for Medicare participation. Thus the definition is reasonable as it is consistent with the federal regulations and its application will assure federal financial participation in paying the costs of services provided by a CORF. See Minnesota Statutes, section 256B.04, subdivision 4 which requires the state to cooperate in any reasonable manner as may be necessary to obtain federal financial participation.

Subp. 2. **Eligibility for payment.** A CORF provides all the rehabilitative and therapeutic services provided by a rehabilitation agency. However, a CORF differs from a rehabilitation agency in that it must have a "coordinated rehabilitation program" that includes, "at a minimum, ...social or psychological services." See 42 CFR 485.58. Further, 42 CFR 485.58 (c) requires a CORF to designate in writing a qualified professional who will coordinate a recipient's services. 42 CFR 485.70 specifies the professionals including psychologists who are to provide the services. This subpart is necessary to set the payment standard for the services of a CORF. Requiring the same standards that are applicable to a rehabilitation agency is reasonable as the services are similar. Not all recipients needing rehabilitative and therapeutic services need mental health services. Permitting payment on a fee for service basis for mental health services provided by a CORF is reasonable as this service is not included within the payment for services provided by a rehabilitation agency nor do all

recipients need mental health services. Thus, payment on a fee for service basis that is made only when mental health services are needed by a recipient conserves the use of medical assistance dollars as required by Minnesota Statutes, section 256B.04, subdivision 15. (It should be noted that payment for mental health services needed by a recipient is in addition to payment for the rehabilitative and therapeutice services needed by the recipient.)

9505.0390 REHABILITATIVE AND THERAPEUTIC SERVICES

Subpart 1. **Definitions.** The definitions in this subpart are necessary to clarify their meaning and set a standard. They are terms used in the present rule part 9500.1070, subparts 12, 13, 14, and 15. The proposed definitions reflect updated standards established by applicable laws or by professional organizations; they remove duplicative and unnecessary language. They also separate out service requirements more properly specified in the body of the part.

Item A. 42 CFR 440.110 (c)(2) defines the term "audiologist". The definition in item A is consistent with the federal regulation. The language of the federal regulation related to a person completing the clinical fellowship year and providing audiological services under supervision is found in subpart 4, item B. The definition is reasonable because it complies with a condition for federal participation as required under Minnesta Statutes, section 256B.04, subdivision 15. See present part 9500.1070, subpart 14, item B.

Item B. The definition is necessary to clarify a term used in these rules. Support personnel do not have the professional qualifications necessary to independently provide therapeutic and rehabilitative services. However, they are qualified to assist the qualified professional therapists according to the appropriate direction of the qualified professionals. This direction assures quality control of the services being provided by the support personnel. The definition in item B is reasonable as it assures the services are directed by fully qualified professional staff and that the qualified person is available on the premises for direct observation and evaluation of the support person's work. 42 CFR 405.1718 requires an onsite supervisory visit every 30 days when services are provided by a qualified physical therapist assistant off the premises of the organization or, if the services are provided on the premises of the organization, the qualified physical therapist must be on the premises at least during the hours when the specific skills of the qualified physical therapist are needed. These skills include evaluation and reevaluation and "appropriate and needed supervision". See part 5601.1400 in regard to delegation of duties of a physical therapist. The present medical assistance rule requires direct on-site observation and supervision by the qualified therapist, without reference to the number of visits or treatment sessions. Most clients require physical therapy more often than once per week. Therefore, the requirement of being on the premises not less than every sixth treatment is less stringent than the present rule and more stringent than the federal regulation. Part 5601.1500 is the Board of Medical Examiners rule related to the delegation of components of a patient's treatment by a physical therapist to a physical therapy assistant, a part of the registration requirements for physical therapists. Item B is consistent with part 5601.1500 in regard to requiring on-site observation at least every six treatment sessions. Part 5601.1600 specifies that a physical therapist may supervise no more than two physical therapy assistants. It is reasonable to be consistent with these rules adopted by the Board of Medical Examiners as the Board has the statutory authority for such regulations under Minnesota Statutes, section 148.70. It is reasonable to apply similar requirements to the services performed by an occupational therapy assistant as the level of training and qualification of an occupational assistant is similar to that of a physical therapy assistant. See the present rule, part 9500.1070, subparts 13, items A and B and 15,

items D and E which permit other personnel to assist a qualified physical therapist or occupational therapist but do not define either "direct on-site observation" or "supervision".

Item C. "Functional status" is a term not used in the present rule. The American Heritage Dictionary of the English Language defines "functional" as "capable of performing" and as "of or pertaining to a function or functions". It defines "function" as "the natural or proper action for which a person...or organ is fitted or employed." The purpose of rehabilitative and therapeutic services is to assist the person to achieve the highest level of performance possible consistent with the person's physical condition. Tasks associated with daily living are natural and proper actions performed by a person. Thus, the definition is reasonable because it is consistent with accepted usage by the professional rehabilitative and therapeutic community according to the advisory committee.

Item D. The definition is the same as the definition in 42 CFR 440.110 (b)(2)(i) Using the definition specified in federal regulations is reasonable because compliance with federal regulations is a condition to obtain federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4. The definition is consistent with the term as defined in present part 9500.1070, subpart 13, item B and subpart 15, item H(6).

Item E. The term "occupational therapy assistant" is not defined in the present rule. The American Occupational Therapy Certification Board is the arm of the American Occupational Therapy Association that sets standards to qualify as an occupational therapy assistant. The Board certifies as occupational therapy assistants those persons who meet its standards. It is necessary to have a standard to determine who is qualified to be an occupational therapy assistant as service from a qualified person is a means of safeguarding against unnecessary or inappropriate services as required under Minnesota Statutes, section 256B.04, subdivision 15. The standard chosen, certification as an occupational therapy assistant by the American Occupational Therapy Certification Board, is reasonable because this Board is comprised of persons who are aware of commonly accepted professional standards for occupational therapy.

Item F. 42 CFR 440.110 (a)(2) specifies who is qualified to be a physical therapist. The definition in item F is the same as the cited federal regulation. Compliance with the federal regulation is reasonable as it is a condition to receive federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4. See also 42 CFR 405.1702 (d) which requires a physical therapist to be licensed by the State in which she or he is practicing if the State licenses physical therapists or to be a graduate of a physical therapy curriculum approved by the Physical Therapy Association or by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association. See present part 9500.1070, subpart 13, item A and subpart 14, item C which define who is qualified as a physical therapist. The proposed definition is consistent with the present definitions and is reasonable as it removes unnecessary language and makes the definition consistent with current standards. It should be noted that there is a proposal to require licensure of physical therapists practicing in Minnesota.

Item G. 42 CFR 405.1702 (e) states that a person who is licensed as a physical therapist assistant by the State in which she is practicing, if the the State licenses such assistants or who has graduated from a 2-year college-level program approved by the American Physical Therapy Association is qualified as a physical therapy assistant. Pursuant to Minnesota Statutes, section 148.70, the Board of Medical Examiners has promulgated rules that define the term "physical therapy assistant". See part 5601.0100, subpart 3. The definition is reasonable as it is consistent with the federal and state regulations. The term is not used in the present rule.

Item H. "Rehabilitative and therapeutic services", a term used in the present rule, part 9500.1070, subpart 12, is a generic term that encompasses all services that are provided for the "purpose of increasing or maintaining

the maximum level of functional independence of patients." Item H defines the term by specifying the broad categories of the service components. See part 9500.1070, subpart 12, which defines "rehabilitative and therapeutic services, and subpart 13, item D which defines restorative therapy and specialized maintenance therapy as rehabilitative services. The definition is reasonable as it is the prevailing standard of paractice and was accepted by the advisory committee. The definition also is reasonable as it brings together the components of the spectrum of rehabilitative services.

Item I. This term, "rehabilitative nursing services" is not used in the present rules. Certain services related to rehabilitation are provided to nursing home residents as routine nursing services that are reimbursed in the nursing home's per diem payment rate. These services are maintenance services necessary to maintain the recipient's current functional status and to prevent the development of deformities or further impairments. The nursing home must provide these services to all residents according to each resident's level of care without receiving extra payment for the services. Item I defines rehabilitative nursing care according to the requirements of part 4655.5900, subparts 2 and 3 which is the rule of the Department of Health setting the standards related to rehabilitation nursing care in licensed nursing homes. Using the standard of the agency responsible for licensing nursing homes is reasonable as the Department of Health has the statutory authority for setting licensing standards for nursing homes and the knowledge of prevailing community standards about services needed by residents of the facilities.

Items J and K. These terms are defined in present part 9500.1070, subpart 13, item D (1) and (2). Some nursing home residents and other persons require rehabilitative and therapeutic services that call for more professional skill and provide more intensive therapy than the nursing home standard of rehabilitation nursing care that is provided by the facility's nursing staff. Items J and K are such therapies that are not provided to a nursing home resident as a condition of nursing home licensure but are provided according to the resident's plan of care. As a consequence payment for these therapies is made on a fee for service basis and is not included within the nursing home's per diem payment. Definitions are necessary to clarify the terms and set a standard. Medicare payment methodolgy implemented by Blue Cross/Blue Shield of Minnesota in its capacity of Medicare intermediary recognizes two categories of rehabilitative and therapeutic services: maintenance therapy which is interpreted to be a therapeutic service provided by a registered nurse less than five times per week and restorative therapy provided at least 5 times per week by a skilled therapist. The department believes three categories of rehabilitative and therapeutic services are necessary to define the services needed by recipients: rehabilitative nursing services as defined in item I, restorative therapy as defined in item J, and specialized maintenance therapy as defined in item K. The service defined in item J is designed to meet the needs of a recipient who has a seriously or acutely impaired function that is expected to be restored to a level consistent with the recipient's limitations through intensive therapy provided by a skilled therapist. The definition is consistent with the Medicare payment methodolgy. Consistency with Medicare payment methodology is reasonable because it is a condition of maximizing federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4. Item K defines a level of therapy that is between the rehabilitative nursing services provided within the nursing home per diem payment rate and the restorative therapy needed by recipients with an acute or serious impairment. Specialized maintenance therapy serves persons who have less serious or less acute impairments that require treatment by a skilled therapist instead of a nurse. These treatments are in addition to and are necessary to assist rehabilitative nursing services and thereby maintain a person's functional status. The treatments also are necessary to minimize the recipient's need for a more intensive level of therapy. The definition in item K is reasonable because it has been recommended by the advisory committee as the prevailing community

standard of practice. That the therapy must be specified in the recipient's plan of care by a physician is consistent with the definition of "plan of care" in part 9505.0175, subpart 35.

Item L. This item defines the term "speech-language pathologist." The term is defined in present part 9500.1070, subpart 13, item C and subpart 14, item A. The proposed definition updates and simplifies the present definitions. The definition is consistent with 42 CFR 440.110 (c)(2)(i). Consistency with the federal requirement is reasonable because it is a condition of maximizing federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4.

Subp. 2. Covered service; occupational therapy and physical therapy. This subpart sets the standards to be eligible for medical assistance payment for occupational and physical therapy provided to a recipient. A standard is necessary to comply with the requirement of Minnesota Statutes, section 256B.04, subdivision 2, of administering the medical assistance program statewide in a uniform manner. Present part 9500.1070 establishes occupational therapy and physical therapy as covered services and sets the conditions for payment in subpart 13, items A and B. The proposed standards clarify the conditions to be eligible as covered services.

Items A and B are consistent with 42 CFR 440.110 (a) and (b). Consistency with federal regulations is reasonable because it is a condition of maximizing federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4.

Item C. Reducing or removing an impairment of a recipient's functional status requires time. For example, restoring the function of a paralyzed muscle requires adequate clinical time and procedures. 60 days is a common professional standard for making progress toward desired therapeutic goals. The item is reasonable because it has been recommended by the advisory committee as consistent with prevailing community standards of practice. The requirement is not in the present rule.

Item D. 42 CFR 405.1717 (b) sets standards to obtain Medicare reimbursement for physical therapy. The standards require the therapy to be specified in the recipient's plan of care and to be reviewed by the recipient's attending physician. 42 CFR 405.1717 (b) also requires the recipient in need of physical therapy to be seen by the physician as "often as the patient's condition requires. In proposing this subpart the department has tried to balance statutory and regulatory requirements: the requirement of Medicare that must be met to obtain reimbursement for services to persons who are Medicare-eligible; the requirement of maximizing federal financial participation under Minnesota Statutes, section 256B.04, subdivision 4; and the requirement of Minnesota Statutes, section 256B.04, subdivision 15 of safeguarding against unnecessary services and excess payments. Item D is reasonable as it meets the conditions necessary to maximize federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4 while at the same time it safeguards against excess medical assistance payments as required under Minnesota Statutes, section 256B.04, subdivision 15. It should be noted that Medicare payments are 100 % federal dollars. See also part 9505.0392, Compliance with Medicare Requirements. Neither medical assistance nor Medicare regulations specify service requirements to obtain payment for occupational therapy. Applying the payment standards of physical therapy to occupational therapy is reasonable because occupational therapy also is a restorative or specialized maintenance therapy that is part of a recipient's plan of care and is designed to restore or maintain the recipient's functional status in a manner consistent with the recipient's physical or mental limitations. The requirement is not in the present rule.

Subp. 3. Covered service; speech-language service. This subpart is necessary to establish medical assistance payment standards for speech-language pathology as a rehabilitative and therapeutic service in order to clarify the rule and administer the medical assistance program statewide in a uniform manner as required by Minnesota Statutes, section

256B.04, subdivision 2. The present rule sets requirements about these services in part 9500.1070, subpart 13, item C and subpart 14, item A. It should be noted that the present rule groups together requirements about speech-language and hearing (audiology) services. The proposed rules set the requirements for these services in two separate subparts, subpart 3, speech-language service and subpart 4, audiology. It is reasonable to separate the requirements because the services involve different qualified professionals and the federal regulatory requirements are not identical. Thus the separation clarifies the requirements and reduces the likelihood of confusion.

Item A is required by 42 CFR 440.110 (c)(1). Requiring a written referral is reasonable because it is evidence of compliance with the requirement of physician referral and thereby reduces the possibility of misunderstanding. See present part 9500.1070, subpart 13, item C and subpart 14, item A which have the requirement of "prescribed by a physician." 42 CFR 483.45 establishes a special requirement in the case of a resident of a long-term care facility, a written order of a physician. Including this requirement in item A is reasonable because compliance with federal regulations is necessary to obtain federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4.

Item B is required by 42 CFR 440.110 (c)(2). Compliance with federal regulations as in items A and B is reasonable because it is a condition of receiving federal financial participation as required by Minnesota Statutes, section 256B.04, subdivision 4. The requirement is not in the present rules.

Item C. Removing or reducing an impairment of a recipient's functional status requires time. For example, restoring the function of an organ, paralyzed by a stroke, that is needed to speak clearly enough to be understood by others requires adequate clinical time and procedures. 60 days is a common professional standard for making progress toward desired therapeutic goals. The item is reasonable because it has been recommended by the advisory committee as consistent with prevailing community standards of practice. The requirement is not in the present rule.

Item D. 42 CFR 405.1717 (b) sets standards to obtain Medicare reimbursement for speech-pathology. The standards require the therapy to be specified in the recipient's plan of care and to be reviewed by the recipient's attending physician. 42 CFR 405.1717 (b) also requires the recipient in need of speech pathology to be seen by the physician. In proposing this item the department has tried to balance three statutory and regulatory requirements: the requirement of Medicare that must be met to obtain reimbursement for services to persons who are Medicare-eligible; the requirement of maximizing federal financial participation under Minnesota Statutes, section 256B.04, subdivision 4; and the requirement of Minnesota Statutes, section 256B.04, subdivision 15 of safeguarding against unnecessary services and excess payments. Item D is reasonable as it meets the conditions necessary to maximize federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4 while at the same time it safeguards against excess medical assistance payments as required under Minnesota Statutes, section 256B.04, subdivision 15. It should be noted that Medicare payments are 100 % federal dollars. See also part 9505.0392, Compliance with Medicare Requirements. The requirement is not in the present rule.

Subp. 4. Covered service; audiology. This subpart sets standards to receive medical assistance payment for an audiology service provided as a rehabilitative and therapeutic service in order to administer the medical assistance program in a statewide uniform manner as required by Minnesota Statutes, section 256B.04, subdivision 2. The present rule sets requirements about audiology in part 9500.1070, subpart 13, item C and subpart 14, item B.

Item A is required by 42 CFR 440.110 (c)(1). Requiring a written referral is reasonable because it is evidence of compliance with the requirement of physician referral and thereby reduces the possibility of misunderstanding.

Item B is required by 42 CFR 440.110 (c)(2). Compliance with federal regulations as in items A and B is reasonable because it is a condition of receiving federal financial participation as required by Minnesota Statutes, section 256B.04, subdivision 4. Proposed item B is similar to present part

9500.1070, subpart 13, item C which defines who is a "qualified audiologist".
Item C. Removing or reducing an impairment of a recipient's functional status requires time. For example, restoring or replacing the function of an organ seriously impaired by illness or injury requires thorough evaluation of the condition and adequate clinical time and procedures. 60 days is a common professional standard for making progress toward desired therapeutic goals. The item is reasonable because it has been recommended by the advisory committee as consistent with prevailing community standards of practice. The requirement is not in the present rule.
Item D. 42 CFR 405.1717 (b) sets standards to obtain Medicare reimbursement for speech-pathology. The standards require the therapy to be specified in the recipient's plan of care and to be reviewed by the recipient's attending physician. 42 CFR 405.1717 (b) also requires the recipient in need of audiology services to be seen by the physician. In proposing this item the department has tried to balance three statutory and regulatory requirements: the requirement of Medicare that must be met to obtain reimbursement for serivces to persons who are Medicare-eligible; the requirement of maximizing federal financial participation under Minnesota Statutes, section 256B.04, subdivision 4; and the requirement of Minnesota Statutes, section 256B.04, subdivision 15 of safeguarding against unnecessary services and excess payments. Item D is reasonable as it meets the conditions necessary to maximize federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4 while at the same time it safeguards against excess medical assistance payments as required under Minnesota Statutes, section 256B.04, subdivision 15. It should be noted that Medicare payments are 100 % federal dollars. See also part 9505.0392, Compliance with Medicare Requirements. The requirement is not in the present rule.
Subp. 5. Covered service; specialized maintenance therapy. This subpart sets the standards for medical assistance payment for specialized maintenance therapy in order to administer the medical assistance program statewide in a uniform manner as required by Minnesota Statutes, section 256B.04, subdivision 5. Specialized maintenance therapy includes physical therapy and occupational therapy. The present rule establishes requirements about specialized maintenance therapy in part 9500.1070, subpart 13, item D(2). Proposed subpart 4 clarifies these requirements and additionally adds requirements which assure consistency with other state and federal laws and regulations.
Item A. This item expands the present rule part cited in the paragraph above by clarifying who is qualified to provide specialized maintenance therapy. 42 CFR 440.110 (a) requires physical therapy to be provided by or under the direction of a qualified physical therapist. Minnesota Statutes, section 148.706 permits a physical therapist to use the services of a physical therapy assistant as specified by rule. Part 5601.1400 specifies the treatment procedures a physical therapist may delegate to a physical therapy assistant. 42 CFR 440.110 (b) requires occupational therapy to be provided by or under the direction of a qualified occupational therapist. An occupational therapy assistant has the qualifications to perform certain tasks related to occupational therapy. See the definition of occupational therapy assistant in subpart 1, item E. Therefore, requiring the service to be provided by persons who meet professional qualifications is reasonable because it assures the recipient a qualified therapist. Compliance with federal regulations is reasonable because it is a condition of receiving federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4.
Item B. 42 CFR 405.1717 (b) sets standards to obtain Medicare reimbursement for physical therapy. The standards require the therapy to be specified in the recipient's plan of care and to be reviewed by the recipient's attending physician. In proposing this item the department has tried to balance three statutory and regulatory requirements: the requirement of Medicare that must be met to obtain reimbursement for services to persons who are Medicare-eligible; the requirement of maximizing federal financial participation under Minnesota Statutes, section 256B.04, subdivision 4; and

the requirement of Minnesota Statutes, section 256B.04, subdivision 15 of safeguarding against unnecessary services and excess payments. Item B is reasonable as it meets the conditions necessary to maximize federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4 while at the same time it safeguards against excess medical assistance payments as required under Minnesota Statutes, section 256B.04, subdivision 15. It should be noted that Medicare payments are 100 % federal dollars. See also part 9505.0392, Compliance with Medicare Requirements. The requirement is not in the present rule.

Item C. This item is not in the present rule which only specifies the need of the therapy for "maintaining the patient's current level of functioning or for preventing deterioration of the patient's condition." It is necessary to clarify who may receive a specialized maintenance therapy. As stated in the SNR of subpart 1, items J and K, the department believes there are three levels of therapy services necessary to provide the full range of services needed by recipients. Specialized maintenance therapy is an intermediate level of service that is less intense than restorative therapy but more intense than rehabilitation nursing care provided as part of routine nursing care by a registered nurse in a nursing home. This item is necessary to specify physical impairments that require an intermediate level of therapy provided by or under the direction of a skilled therapist. See part 4655.5900, subparts 2 and 3 which specify the services that constitute rehabilitation nursing care or rehabilitative nursing services. The conditions in subitems (1) to (5) are similar to those usually treated through rehabilitative nursing service but differ by having a level of acuity that is more severe than appropriate for routine care. For example, an activity of daily living (subitem 1) is the daily bed bath given as part of routine nursing care to a nursing home resident. If the resident's spasticity or contracture interferes with such an activity of daily living, for example, by preventing the nurse from unfolding the contracted fingers, care of the spasticity or contracture prevents routine nursing care from occurring. Under this circumstance, it is necessary and reasonable to seek services from a person skilled in providing the therapy necessary to reduce or relieve the spasticity or contracture so the nurse is able to provide nursing services such as skin hygiene or daily range of motion. A chronic condition related to physiological deterioration as in subitem (2) sometimes occurs with a condition such as cerebral palsy. Treatment of such a condition requires additional specialized maintenance therapy services in order for the nurse to perform daily nursing care and thus assist in the completion of the recipient's activities of daily living. Similarly treatment of an orthopedic condition leading to physiological deterioration as in subitem (3) requires services which call for specialized knowledge related to bones, their articulation, and the tissues connected to them. It is reasonable to specify that the therapy be provided by an occupational therapist or a physical therapist as these professionals are qualified by training to treat orthopedic conditions through therapy. Subitem (4) relates to chronic pain that interferes with functional status and cannot be adequately treated with medication and rehabilitative nursing care. Therefore other means must be used to relieve the pain. An example is a situation in which medication is used to relieve pain associated with severe spasticity and the medication also interferes with range of motion. This condition has a level of acuity more severe than appropriate for routine nursing care. The care is appropriately provided by a skilled therapist. It is reasonable to specify that the pain be of such a nature that a physician expects it to respond to therapy as such an expectation assures the treatment meets the required medical assistance service standard of medical necessity. (See part 9505.0210, item A.) An example of a condition requiring an intermediate level of therapy is a skin breakdown, subitem (5), that occurs when uncut fingernails dig into and injure the skin on the palms of the recipient's hands. The condition occurs because of severely contracted fingers which require a therapy procedure. A similar skin breakdown, requiring therapy for prevention and remediation, can occur behind severely

contracted knees. Thus, subitems (1) to (5) are reasonable as they relate to conditions requiring treatment from a skilled therapist that is beyond the care provided through nursing care but the conditions are not severe enough to require a more intense therapy level such as restorative therapy.

Subp. 6. Payment for rehabilitative nursing service in long-term care facility. Several rules specify the long-term care facility services that are to be provided as part of the service paid for through the long-term care facility's per diem payment rate. These services are considered to be routine nursing services available to all residents of long-term care facilities who need them. See the definition of rehabilitative nursing service and its SNR. The subpart is necessary to clarify the standard to obtain payment for these services when they are not to be provided through the per diem payment rate. The subpart is consistent with the cited rules which include payment for rehabilitative nursing services within the facility's per diem payment rate. The subpart is reasonable because it prevents duplicate payments for the same service as required under Minnesota Statutes, section 256B.04, subdivision 15. This proposed subpart clarifies the present rule, 9500.1070, subpart 13, item F which lists the services that are not separately billable by a long-term care facility. It should be noted that the adoption of the present rule took place before the adoption of parts 9549.0010 to 9549.0080 and 9553.0010 to 9553.0080, which set the standards for determining the services whose cost is included within the long-term care facility's per diem payment rate. Thus it is reasonable to reference the rules established to determine the standards applicable to long-term care facilities in order to insure consistency between rules and avoid confusion.

Subp. 7. Payment limitation; therapy assistants and aides. This subpart specifies a medical assistance payment limitation applicable to services provided by physical or occupational therapy assistants or aides. A standard is necessary to administer the medical assistance program statewide in a uniform manner as required by Minnesota Statutes, section 256B.04, subdivision 2. 42 CFR 440.110 (a) (1) requires physical therapy to be provided by or under the direction of a physical therapist. A physical therapy assistant is trained to use certain therapies under the supervision of a physical therapist. See parts 5601.0100, subpart 3 which defines defines physical therapy assistant and 5601.1400 which authorizes a physical therapist to delegate certain patient treatment procedures to an assistant. Permitting a physical therapy assistant to carry out certain therapies under the direction of a physical therapist is reasonable as the assistant is qualified by training and experience and the delegation is consistent with rules related to physical therapy practice. Neither statutes or rules establish any standards to qualify as a physical therapy aide nor permit a physical therapist to delegate certain therapy procedures to an aide. In physical therapy, an aide is used as an adjunct to the therapy function, that is, the aide prepares the recipient for the therapy but does not provide it. Thus, denying separate payment for these adjunctive services is reasonable as the aide does not actually provide a therapy service. These requirements are consistent with 42 CFR 441.110 (a). See present part 9500.1070, subpart 13, item F, subitem (2) which specifies that the cost of services by unsupervised assistants and aides are to be included as part of the facility's rate determination.

Another therapy requiring training and experience is occupational therapy. Although Minnesota Statutes at present do not set standards for licensure of occupational therapists or delegation of duties of occupational therapists, such standards are set by the American Occupational Therapy Association. See part 9505.0390, subpart 1, items D and E. See also 42 CFR 440.110 (b) which defines occupational therapy and permits occupational therapy to be provided under the direction fo a qualified occupational therapist. The training and experience required of an occupational therapy assistant are less than those required of an occupational therapist. Thus requiring an occupational therapy assistant to provide services under the direction of an occupational therapist is reasonable as it ensures the client's therapy is being directed by a therapist who meets the qualifications.

This subpart is consistent with federal regulations. Consistency with federal regulations is reasonable because it is a condition of receiving federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4.

Subp. 8. Excluded restorative and specialized maintenance therapy services. See present part 9500.1070, subpart 13, item F, subpart 14, item D, and subpart 15, item D for language corresponding to proposed subpart 8. This proposed subpart brings together in one place the therapy services that are not eligible for medical assistance payment and thus clarifies which restorative and specialized maintenance therapy services are not eligible for medical assistance payment. Clarification is necessary to set a standard and avoid confusion.

Item A. 42 CFR 440.110 (a) requires physical therapy to be prescribed by a physician as a condition for medical assistance payment. 42 CFR 440.110 (b) requires occupational therapy to be prescribed by a physician as a condition for medical assistance payment. Meeting the federal requirement is a condition of receiving federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4. (Also see proposed part 9505.0390, subpart 2 and its SNR.) Therefore, it is reasonable to exclude from medical assistance payment services which do not meet federal standards in order to comply with Minnesota Statutes.

Item B. 42 CFR 440.110 (c) requires services for individuals with speech, hearing, and language disorders to be provided upon the referral of a physician. Meeting the federal requirement is a condition of receiving federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4. Therefore, it is reasonable to exclude from medical assistance payment services which do not meet federal standards in order to comply with Minnesota Statutes. Also see proposed part 9505.0390, subparts 3 and 4 and their SNRs.

Item C. Services that are included in the costs covered by the per diem payment to a long-term care facility have received medical assistance reimbursement as provided in 9549.0010 to 9549.0080 or 9553.0010 to 9553.0080. Minnesota Statutes, section 256B.04, subdivision 15 prohibits duplicate medical assistance payments for the same services. Thus, this item is reasonable because it prevents duplicate payments. The services listed in subitems (1) to (5) are routine nursing activities that are encompassed in the prevailing community standard of the practice of professional nursing. See part 4655.5900 which specifies the rehabilitation nursing care that a long-term care facility is required to provide for licensure by the Department of Health. Subitems (1) to (5) are consistent with the specific procedures required of a long-term care facility in subpart 3 of part 4655.5900. Also see proposed part 9505.0390, subpart 6 and its SNR and the present rule, part 9500.1070, subpart 13, item F (3).

Items D and E. Minnesota Statutes, section 256B.04, subdivision 15 prohibits medical assistance payment for services that are not medically necessary. These items are consistent with the statutory requirement and with part 9505.0210, item A which specifies that eligibility for medical assistance payment is limited to services that are medically necessary. See also 42 CFR 440.230 (d). The specific restriction about arts and crafts in proposed item D is not in the present rule in subparts 12 to 15 but is necessary and reasonable to clarify the nature of certain activities that may be confused with related ones of a therapeutic nature that are medically necessary.

Item F. This item prohibits medical assistance payment for a service that is not documented in the recipient's plan of care. The prohibition is consistent with parts 9505.0220, item O and 9505.1800. Consistency with other rules of the medical assistance program is reasonable in order to avoid confusion and ensure compliance with Minnesota Statutes, section 256B.04, subdivision 2 in regard to uniform administration of the medical assistance program. A similar exclusion is found in present part 9500.1070, subpart 13, item F(1).

Item G. This item prohibits medical assistance payment for a therapy that is

as required under Minnesota Statutes, section 256B.04, subdivision 4. Finally requiring the therapist to maintain an office at her own expense is reasonable as it is a criterion of the therapist's independent practice. A similar requirement is found in the present rule, part 9500.1070, subpart 14, item D(1).

9505.0392 COMPLIANCE WITH MEDICARE REQUIREMENTS

As discussed above in the SNR of part 9505.0391, the department wants to maximize federal financial participation in the costs or rehabilitative and therapeutic services to persons who are both Medicare beneficiaries and medical assistance recipients. This part is necessary to clarify that a provider who is denied Medicare payment for service on the basis of failing to comply with Medicare requirements is not eligible for medical assistance reimbursement for the service. Denial of medical assistance payment in this case is reasonable because it provides an incentive for the provider to comply with the requirement and is consistent with the requirement of Minnesota Statutes, section 256B.04, subdivision 4 in regard to maximizing federal financial participation.

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

The present rule in subpart 13 of part 9500.1070 sets standards applicable to rehabilitative and therapeutic services in long-term care facilities. Many of the standards of subpart 13 have general application to all rehabilitative and therapeutic services. Thus, proposed part 9505.0410 clarifies the applicability of general standards for the provision of rehabilitative and therapeutic services to residents of long-term care facilities by citing the applicable rule provisions rather than repeating the requirements. The citations are reasonable because they shorten the rules and reduce possible confusion about applicable provisions.

Subpart 1. Eligible providers. Recipients who reside in long-term care facilities may receive needed rehabilitative and therapeutic services through several types of providers: the long-term care facility itself; a rehabilitation agency or a comprehensive outpatient rehabilitation facility; a physical therapist in independent practice; or a speech-language pathologist or audiologist. This part is necessary to establish who is eligible for payment as a provider of these rehabilitation and therapeutic services to the resident of the facilities. This subpart is reasonable as it coordinates the various rules governing rehabilitation and therapeutic services under the medical assistance program and informs affected parties. See item E of present rule, 9500.1070, subpart 13 for existing provisions about billing and reimbursement of long-term care facilities for rehabilitative services.

Subp. 2. Payment limitation. This subpart is necessary to clarify the standard to receive medical assistance payment for rehabilitative and therapeutic services provided to recipients residing in a long-term care facility. Applying the standards of part 9505.0390 is reasonable because a single set of standards assures consistency among the medical assistance rules related to rehabilitative and therapeutic services and is equitable to providers of similar services. The present rule does not have this provision.

Subp. 3. Payment for restorative therapy and specialized maintenance therapy. This subpart is necessary to clarify the standard to receive medical assistance payment for restorative therapy and specialized maintenance therapy provided to residents of long-term care facilities. The subpart permits payment to be made on a fee for service basis or as an allowable operating cost in establishing the facility per diem payment. Allowing the facility a choice is reasonable as choice may be advantageous to the facility. The choice is consistent with part 9549.0036, item X and part 9549.0040, subpart 6, item B in regard to nursing homes and with part 9553.0036, item V and part 9553.0040, subpart 6 in regard to intermediate care facilities for persons with mental retardation or related conditions.

See item D of subpart 13 of the present rule, part 9500.1070 for a similar provision.

Subp. 4. Payment for rehabilitative nursing services. This subpart is necessary to clarify how medical assistance payment will be made for rehabilitative nursing services. As discussed in the SNR of part 9505.0390, subpart 1, item I, rehabilitative nursing service must be available to residents of a long-term care facility as a condition of licensure and is a function of the facility's nursing staff. Nursing costs are reimbursed through the facility per diem payment as provided in parts 9549.0010 to 9549.0080 or 9553.0010 to 9553.0080, as applicable. Prohibiting a separate payment for rehabilitative nursing services therefore is reasonable because it avoids duplicate payment for the same service as required under Minnesota Statutes, section 256B.04, subpart 15. A similar provision is found in the present rule, part 9500.1070, subpart 13, item F (3).

Subpart 5. Reporting of fees for service by long-term care facility. This subpart requires a long-term care facility to report therapy income derived from fees for service according to the rules that establish the procedures for determining the payment rates for nursing homes (parts 9549.0010 to 9549.0080) or intermediate care facilities for persons with mental retardation or related conditions (parts 9553.0010 to 9553.0080.) This subpart is necessary to clarify the treatment of therapy payments received on a fee for service basis. The reporting requirement is reasonable because it coordinates rules applicable to medical assistance services and avoids duplicate payments for the same services as required under Minnesota Statutes, section 256B.04, subpart 15. Proposed subpart 5 clarifies and updates the billing procedures of the present rule, part 9500.1070, subpart 13, item E.

A definition of the term "related organization" is necessary to clarify its meaning. The definition is reasonable because it relies on the meaning established in Minnesota Statutes.

Subpart 6. Prohibited practices. This subpart is necessary to inform affected persons of a practice prohibited by sections 1877 (b) and 1909 (b) of the Social Security Act and of the limitations on separate billings for therapy services set forth in Minnesota Statutes, section 256B.433, subdivision 3. Including this information in the rule is reasonable so that the affected persons have an opportunity to comply.

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

This part clarifies that a long-term care facility may receive medical assistance payment for rehabilitative and therapeutic services provided to recipients who are not residents of long-term care facilities but who receive the services on an outpatient basis. In greater Minnesota, a long-term care facility may be the only place for a recipient living in the community to receive needed rehabilitation and therapeutic services. Therefore, allowing a facility to provide such services on an outpatient basis is reasonable as it assists recipients who need the services. Requiring Medicare certification as a provider of outpatient therapy under 42 CFR part 405, subpart Q and adherence to standards applicable to rehabilitative and therapeutic services as medical assistance covered services is reasonable because it assures that the services will be eligible for Medicare reimbursement, that federal financial participation will be maximized as required under Minnesota Statutes, section 256B.04, subdivision 4, and that all providers of comparable services are treated equitably. Finally limiting medical assistance payment to outpatient therapy services to those persons who are not residents of long-term care facilities is reasonable because it prevents the excessive payments that might result if one long-term care facility were to transport its residents to another long-term care facility for rehabilitation and therapeutic services. The limitation is consistent with Minnesota Statutes, section 256B.04, subdivision 15 requires the department to safeguard against such excess payments. The present rule does not have this provision.

9505.0412 REQUIRED DOCUMENTATION OF REHABILITATIVE AND THERAPEUTIC SERVICES. Although the present rule, part 9500.1070, in subparts 12 to 15 contains requirements that therapy services be prescribed by a physician and stated in a written treatment plan, it does not specify the components of the plan of care or the record of the recipient's services. This part sets standards applicable to all rehabilitative and therapeutic services about the required recipient records. Standards are necessary in order to assure uniform administration of the medical assistance program as required by Minnesota Statutes, section 256B.04, subdivision 2.

Item A. Unless 42 CFR 424.25 applies, 42 CFR 485.58 (b) requires a physician to establish a plan of care for a recipient receiving therapy services through a comprehensive outpatient rehabilitation facility and to review and, if necessary, revise the plan at least every 60 days. Requiring the physician's review and, if necessary, revision is reasonable because it assures that the plan is up-to-date and will fit the recipient's current needs for therapy. This item is consistent with the federal regulation. Consistency with federal regulations is a condition of receiving federal financial participation as required by Minnesota Statutes, section 256B.04, subdivision 4. Using the one standard for therapy services is reasonable because a single standard complies with the requirement of Minnesota Statutes, 256B.04, subdivision 2 of administering the medical assistance program statewide in a uniform manner. See also 42 CFR 405.1717(b) which applies to Medicare recipients. Thus, the item also is consistent with a requirement to receive Medicare reimbursement.

Item B. This item specifies the contents of a plan of care. A standard is necessary to assure uniform administration of the medical assistance program as required under Minnesota Statutes, section 256B.04, subdivision 2. The required information listed in subitems (1) to (4) meets the prevailing community standards for therapy services according to the advisory committee. Subitem (1) is necessary to determine why the recipient needs the therapy. A contraindication to therapy is a condition under which therapy is not beneficial or may be harmful to the recipient. Subitem (2) is necessary to establish a baseline, determine the objectives of the service (subitem (3)), and measure the recipient's progress. Thus, subitems (1) to (4) are reasonable as they determine the recipient's needs and progress toward goals that can be attained through rehabilitative and therapeutic services. The subitems are reasonable because they provide evidence that the services are medically necessary.

Item C. This item requires the recipient's physician to sign the recipient's plan of care. Requiring the physician's signature is reasonable as it is evidence that the physician has had an opportunity to review the plan of care. As stated in item A, the physician is the individual responsible for the review and revision of the recipient's plan of care.

Item D. This item requires specific information needed to identify the person receiving therapy, the provider, the type and length of therapy, and the dates on which the therapy is given. The information is consistent with the community standards for medical charting as accepted by the advisory committee. The information is reasonable because it provides an audit trail for medical assistance payment purposes. Additionally, the requirements are reasonable because they are consistent with safeguarding against unnecessary or inappropriate services as required by Minnesota Statutes, section 256B.15, subdivision 15.

Effective date. Unless otherwise specified, proposed rules become effective five working days after a notice of their adoption is published in the State Register. See Minnesota Statutes, section 14.18. The department believes that a period longer than 5 days is necessary so that the department can fully inform affected providers of the requirements to receive medical assistance payment for therapeutic and rehabilitative services. Therefore, an effective date of July 1, 1991 provides time for the department to prepare provider manual material consistent with the adopted rules, to distribute the

material to all enrolled providers, and to respond to the initial questions and concerns raised by providers.

EXPERT WITNESSES

The Department does not plan to have outside experts testify on behalf of this rule when it goes to public hearing.

November 19, 1990

ANN WYNIA, Commissioner
Department of Human Services

ADVISORY COMMITTEE ON RULE 47

REHABILITATIVE AND THERAPEUTIC SERVICES
in the MEDICAL ASSISTANCE PROGRAM

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