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STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of Proposed Amendments of Rules of the Department of Human Services Governing Conditions for Medical Assistance and General Assistance Medical Care Reimbursement, Minnesota Rules, Part 9505.5015, After the Fact Authorization

STATEMENT OF NEED AND REASONABLENESS

INTRODUCTION

Minnesota Rules, parts 9505.5000 to 9505.5030 were adopted in October 1985 and establish procedures for prior authorization of health services provided to recipients of medical assistance or general assistance medical care. Prior authorization is a condition of reimbursement under the medical assistance and general assistance medical care programs for certain health services as designated under parts 9505.0170 to 9505.0475 and 9505.5025, and Minnesota Statutes, section 256B.0625, subdivision 25.

Prior authorization is one of the systems used in the medical assistance and general assistance medical care programs to safeguard against unnecessary use of health care services as required by Minnesota Statutes, section 256B.04, subdivision 15. Prior authorization refers to the Department's issuance of an authorization number to a recipient's health service provider. The procedure provides the Department an opportunity to review and to assure that the recipient actually needs the proposed health service, that all appropriate, less expensive alternatives have been considered by the provider, and that the proposed service conforms to commonly accepted community standards of the profession or health specialty involved. Usually, the procedure must take place before the service

is provided. However, certain circumstances, such as an emergency, permit the provider to provide the service necessary to meet the emergency before submitting the request for authorization. The rule amendments are being proposed in the portion of the procedure related to after the fact authorization.

The proposed amendments clarify and provide additional provider flexibility about rule requirements that are already in effect. Organizations of providers of health services requiring prior authorization were sent copies of the proposed amendments and asked to review and comment on the proposed amendments. See Attachment A, list of organizations and Attachment B, copy of letter. The Department received two written responses supporting the amendments and no comments opposing them.

Authority for the proposed rule amendments is in Minnesota Statutes, sections 256.991 and 256D.03.

PROPOSED AMENDMENTS

Part 9505.5010, subpart 1, Provider requirements.

This amendment is a technical amendment that is necessary to delete the reference to a rule and its subparts which have been repealed.

Part 9505.5015 AFTER THE FACT AUTHORIZATION

Subpart 1. Exceptions. The proposed amendment clarifies that the provider may use either form DHS-1856 or form DHS-1855, in submitting the request for after the fact authorization. This is a technical amendment that provides flexibility.

Subp. 2. Emergencies. The proposed amendment removes the time limitation for submitting a request for authorization after providing the initial service if the provider documents that the service was given to meet an emergency. Under the existing rule, providers have been denied payment for a medically necessary service provided in an emergency because the request for authorization was not submitted timely. The Department believes that a five day time limit in which to submit the request is not reasonable because it is not consistent with the community standard of professional practice and because it focuses attention on a procedural requirement rather than the required standard of safeguarding against unnecessary services specified in Minnesota Statutes, section 256B.04, subdivision 15. The community standard is to document the nature of the emergency and the date the service was provided. A second amendment clarifies that billing for emergency services must comply with part 9505.0450 which applies to billings for medical assistance and general assistance medical care services. The clarification is reasonable as it informs affected persons of the standard that replaces the timeline of five working days. This subpart also is being amended to delete "prior" as a modifier of "authorization". This is a reasonable technical amendment related to language structure, reflecting the fact that the term "after the fact prior authorization" is illogical.

Subp. 3. Retroactive eligibility. The present rule requires a provider to submit an authorization request within 20 days of the date a case is opened for a recipient whose service was provided on or after the date on which the recipient became eligible but before the date the case was opened. The Department notes that in many cases clients do not immediately notify their service providers as soon as they are determined eligible for medical assistance

in a past period. Thus, under the present time requirement, the effect of a delay in informing a provider may be to deny a provider payment for services that were medically necessary. Lengthening the period to 180 days in which to request retroactive authorization is reasonable as the decision about authorization is properly based on the medical necessity of the service for the recipient rather than compliance with a time period that may be insufficient to allow the information about eligibility to be given to the service provider.

Subp. 4. Third party liability. This subpart is being amended to lengthen the time available for submitting an authorization request from 20 to 180 days when the health service provider who wants to receive payment of the difference between the medical assistance or general assistance medical care payment rate and the payment by a third party payer. This is a retroactive request. The provider furnished the health service to a person who had both third party coverage which did not require prior authorization of the service and medical assistance eligibility. The provider, as required under part 9505.0070 if a recipient has third party coverage in addition to medical assistance eligibility, first billed the third party payer. However, the third party payer did not pay an amount equal to the medical assistance payment rate for the service. Therefore, the provider under this subpart may bill medical assistance for the difference. The time extension to 180 days is necessary because in many cases 20 days is insufficient time to allow for a delay in clients' notifying providers of a payment made by a third party. 180 days is reasonable as it is consistent with the revised time limitation proposed in subpart 3 and balances the need to consider delayed information and timely action on requesting payment.

Subp. 5. Authorization of dental prostheses. Part 9505.0270, subpart 4 requires prior authorization of all removable dental prostheses. Proposed subpart 5 revises the prior authorization requirement for dental prostheses to permit a provider to obtain after the fact authorization of a dental prosthesis if the request meets a criterion specified in part 9505.0270, subpart 4. In many cases the recipient at the time of the service does not inform the dental service provider about being medical assistance eligible or the recipient becomes eligible through meeting a spenddown. (See part 9505.0065, subpart 11, which specifies requirements about eligibility based on spenddown. The recipient's ability to meet a spenddown requirement may result, at least in part, from the cost of the dental prostheses.) This is reasonable as it assures the decision about authorization will be based on the medical necessity of the request as required under Minnesota Statutes, section 256B.04, subdivision 15.

Subp. 6. Authorization of medical supplies or equipment for recipient being discharged from hospital or long-term care facility. As authorized in Minnesota Statutes, section 256B.0625, subdivision 25, certain medical supplies and equipment have been listed in the State Register as health services that require prior authorization. Among these medical supplies and equipment are items needed by recipients who are being discharged from hospitals or long-term care facilities to their homes and for whom the use of the medical supplies and equipment in their homes is medically necessary to enable their safe discharge to their homes. Because at present prior authorization is required, the discharge of a recipient who has been determined by a physician as ready for discharge is sometimes delayed while the required prior authorization is requested and obtained. Delaying the recipient's discharge for purposes of

complying with a procedural requirement is not consistent with the community standard of professional practice nor is it consistent with the standard of safeguarding against unnecessary services as required by Minnesota Statutes, section 256B.04, subdivision 15. Proposed subpart 6 permits after the fact authorization of medical supplies or equipment requiring prior authorization in the case of a recipient being discharged from a hospital or long-term care facility. The proposed subpart is reasonable because it enables the recipient's discharge to be dependent upon the physician's determination of the recipient's condition and necessary services rather than upon compliance with a procedure. Criteria are necessary to determine when to grant after the fact authorization in order to establish a uniform standard and avoid arbitrary and capricious decisions. Items A to D are the criteria the medical supply or equipment must meet to receive after the fact authorization. Item A is reasonable as it informs the Department. Item B is reasonable as the information enables the Department to relate the date of the recipient's discharge to the request for after the fact authorization. Only trained health care staff who may not be available to the client at home are able to appropriately use some medical supplies and equipment without running the risk of possible threat to the client's health and safety; the use of other medical and supplies equipment is limited to persons holding the required licensure; and some medical supplies and equipment cannot be appropriately used in a recipient's home because of physical limitations of the client's residence. Item C limits the authorization to medical supplies and equipment that are appropriately used in the recipient's home. The limitation is reasonable as it serves to protect the recipient and to assure that the supplies and equipment will be able to be used. It is also reasonable to require the supplies and equipment to be specified in the recipient's discharge plan as

the plan is the document developed by the recipient's care provider to specify the health services that are necessary and appropriate to complete the recipient's recovery, or to maintain the recipient in a stable condition, after the recipient's discharge. Part 9505.0310 establishes the conditions to receive medical assistance payment for medical supplies and equipment. Item D is reasonable as it applies the established standard for medical supplies and equipment, part 9505.0310, to medical assistance recipients being discharged to home care and thereby assists the uniform administration of the medical assistance program as required by Minnesota Statutes, section 256B.04, subdivision 2. It is reasonable to inform affected persons of the established standard.

EXPERT WITNESSES

In the event a public hearing is required, the Department will not present expert witnesses other than Department staff members to testify on behalf of the Department concerning the provisions of these proposed amendments to the rules.

Date: November 13, 1991

George Steffen

for NATALIE HAAS STEFFEN, Commissioner

Department of Human Services