This document is made available electronically by the Minnesota Legislative Reference Library as part of an ongoing digital archiving project. http://www.leg.state.mn.us/lrl/sonar/sonar.asp

Legislative Reference Library
645 State Office Building
100 Constitution Avenue
St. Paul, Minnesota 55155
January 28, 2013

Re: Proposed Amendments to Rules of the Minnesota Department of Human Services Governing Medical Assistance (MA): Rehabilitative and Therapeutic Services, Therapists Eligible to Enroll as Providers, Required Documentation of Rehabilitative and Therapeutic Services Minnesota Rules, parts 9505.0390, 9505.0391, 9505.0412; Tracking number R-04133

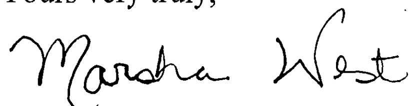
Dear Librarian:

The Minnesota Department of Human Services intends to adopt proposed amendments to permanent rules governing Medical Assistance (MA) and rehabilitative and therapeutic services via the permanent rulemaking process. We published a Dual Notice of Intent to Adopt Rules Without a Public Hearing Unless 25 or More Persons Request a Hearing and Notice of Hearing If 25 or More Requests for Hearing are Received in the Monday, January 28, 2013 issue of the *State Register*.

The department has prepared a Statement of Need and Reasonableness. As required by Minnesota Statutes, sections 14.131 and 14.23, the department is sending the Library a copy of the Statement of Need and Reasonableness.

If you have questions, please contact me at 651-431-3612.

Yours very truly,



Marsha West
Rulemaker

Enclosure: Statement of Need and Reasonableness

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED AMENDMENTS OF RULES OF THE DEPARTMENT OF HUMAN SERVICES GOVERNING REHABILITATIVE AND THERAPEUTIC SERVICES, THERAPISTS ELIGIBLE TO ENROLL AS PROVIDERS, REQUIRED DOCUMENTATION OF REHABILITATIVE AND THERAPEUTIC SERVICES; MINNESOTA RULES, PARTS 9505.0390, 9505.0391, 9505.0412.	**STATEMENT OF NEED AND REASONABLENESS**

INTRODUCTION

This statement of need and reasonableness is prepared pursuant to Minnesota Statutes, sections 14.131 and 14.23. It summarizes the rationale supporting the amendments of the rules governing Medical Assistance (MA) payments.

ALTERNATIVE FORMAT

This information is available in other forms to people with disabilities by contacting us at (651) 431-3600 (voice) or toll free at (800) 657-3510. TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

BACKGROUND

Medical Assistance (MA) is the largest of Minnesota's publicly funded health care programs. It provided coverage for a monthly average of 733,000 low-income people in state fiscal year 2012.

Minnesota Rules, parts 9505.0170-9505.0475 (informally known as "Rule 47") govern the administration of the Medical Assistance program, establish the services and providers that are eligible to receive Medical Assistance payments, and establish the conditions a provider must meet to receive payment. Minnesota rules, parts 9505.0235-9505.0420 set forth the specific health services that are eligible for payment under the Medical Assistance program.

The proposed amendments to Minnesota Rules, parts 9505.0390, 9505.0391, and 9505.0412 affect Medical Assistance rehabilitative and therapeutic services. Specifically, the department wishes to amend Minnesota Rules, parts 9505.0390, 9505.0391, 9505.0412 entitled "Rehabilitative and therapeutic services," "Therapists eligible to

enroll as providers," and "Required documentation of rehabilitative and therapeutic services," respectively.

Minnesota Rules, parts 9505.0390, 9505.0391, and 9505.0412 were first added to rule standards governing medical assistance in 1991

These parts established standards to enroll therapists who may receive medical assistance payments for providing rehabilitative and therapeutic services. In 2001, Minnesota Rules, part 9505.0390 was amended to make technical and editorial changes to definitions of the rule and make the definitions consistent with statutory and regulatory language. In 2008, Minnesota Rule, part 9505.0391 was amended to allow the department to enroll physical and occupational therapists, speech-language pathologists, and audiologists as providers when they are employed by physician clinics and other such facilities. Minnesota Rules, part 9505.0412 has not been amended since 1991.

As Minnesota Rule, part 9505.0390 is presently written, the definitions do not reflect current industry standards and practices for the registration, accreditation, or certification of providers of rehabilitative and therapeutic services and needs to be updated. The department also proposes to add language that states that providers of rehabilitative and therapeutic services must maintain an applicable state licensure or be in compliance with state regulatory requirements in states that do not license. It is reasonable and necessary to add this language to the rule because in Minnesota, providers of rehabilitative and therapeutic services are required to be licensed. However, the department also recognizes that not all states require licensure of these providers and Medical Assistance recipients may travel to states in which these providers are not required to be licensed. The language ensures that these providers are either licensed by the state in which they practice or in compliance with their state's regulatory requirements.

Minnesota Rules, part 9505.0391 is being amended to require speech-language pathologists and audiologists to enroll and submit claims directly to Medicare which is the current practice.

For Minnesota Rules, part 9505.0390 and 9505.0412, the department also proposes changing the 60 day review period for a recipient's plan of care to 90 days. Originally, when this language was added to the rule in 1991, the department justified the 60 day standard because 60 days was a common professional standard for making progress toward desired therapeutic goals. In 2008, 42 C.F.R. 485.711 was revised which specified the plan of care and physician involvement for outpatient physical therapy or speech pathology services. The regulation now states that the plan of care is to be reviewed by the physician or by the individual who established the plan at least as often as the patient's condition requires, and the indicated action is taken instead of every 30 days. The Centers for Medicare & Medicaid Services (CMS) recommended in their memorandum dated January 16, 2009 that the plan of care must be reviewed at least every 90 days. The department believes it is reasonable to apply a 90 day review period for a plan of care because this is consistent with industry practices.

Moreover, the department recommends editorial edits and changes to ensure the rule language reflects the most current state statutory and federal regulatory requirements. The department suggests replacing the word "direction" with "supervision" because this is the terminology currently used in Minnesota Statutes, sections 148.6432 and 148.706, which define the supervision of occupational therapist assistants and physical therapy assistants, respectfully. Additionally, the department is replacing outdated rule language with the relevant federal regulation and state statutory citations that would allow the rule language to remain current without the need to change the rule periodically.

In accordance with Minnesota Statutes, section 14.127, the department also determined that the cost of complying with the proposed rule changes in the first year after the rule takes effect would not exceed $25,000 for businesses. Nothing in the proposed rule changes would shift or create additional expenses for current and potential providers of therapeutic or rehabilitative services.

In accordance with Minnesota Statutes, section 14.128, the department has determined that a local government will not be required to adopt or amend an ordinance or other regulation to comply with the changes the department proposes to Minnesota Rules, parts 9505.0390, 9505.0391, and 9505.0412 entitled "Rehabilitative and therapeutic services," "Therapists eligible to enroll as providers," and "Required documentation of rehabilitative and therapeutic services," respectively. The department is the only government unit affected by the rule change because the department is the only government unit in the state that administers the Medical Assistance program.

A request for comments was published in the State Register on Monday, September 10, 2012, (37 SR 383). No comments were received during the 60 day comment period.

A draft statement of need and reasonableness (SONAR) for these rules was made available since December 2012 via the department's public website or by notifying the department's contact person for these rules.

The Minnesota Management & Budget Department reviewed the rules and the statement of need and reasonableness on January 25, 2013 and determined that there would be no fiscal impact to local governments from the proposed rule change.

The department published the Dual Notice in the State Register on Monday, January 28, 2013, If the department received 25 or more requests for a hearing, a hearing would have been held on Friday, April 12, 2013.If a hearing is held, the department plans to call Steve Masson, for the Health Care Management, Benefits Policy, and Provider Relations Division of the Minnesota Department of Human Services as a witness.

On Monday, January 28, 2013, a copy of the statement of need and reasonableness, was sent to the Legislative Reference Library in accordance with Minnesota Statutes, sections 14.131 and 14.23.

On Monday, January 28, 2013, a copy of the Dual Notice and the rules were mailed to everyone on the department's rulemaking mailing list in accordance with Minnesota Rules, part 1400.2080, subpart 6.

On Monday, January 28, 2013, a copy of the dual notice, rules, and statement of need and reasonableness, were sent to the following chairs and ranking minority party members of the legislative policy and budget committees in accordance with Minnesota Statutes, section 14.116:

Senator David W. Hann, Chair, and Senator Tony Lourey, Ranking Minority Party Member of the Health and Human Services Committee;

Senator David H. Senjem, Chair, and Senator Thomas M. Bakk, Ranking Minority Party Member of the Rules and Administration Committee;

Representative Jim Abeler, Chair and Representative Thomas Huntley, Ranking Minority Party of the Health and Human Services Finance Committee;

Representative Steve Gottwalt, Chair and Representative and Representative Tina Liebling, Ranking Minority Party of the Health and Human Services Reform Committee;

Representative Matt Deant, Chair and Representative Sarah Anderson, Ranking Minority Party of the Rules and Legislative Administration Committee.

STATUTORY AUTHORITY

The commissioner of the Minnesota Department of Human Services is authorized by Minnesota Statutes, section 256B.04, subdivision 2 to, "Make uniform rules, not inconsistent with law, for carrying out and enforcing the provisions hereof in an efficient, economical, and impartial manner, and to the end that the medical assistance system may be administered uniformly throughout the state, having regard for varying costs of medical care in different parts of the state and the conditions in each case, and in all things to carry out the spirit and purpose of this program, which rules shall be furnished immediately to all county agencies, and shall be binding on such county agencies."

REGULATORY ANALYSIS

The department is required to exert reasonable efforts to ascertain who is likely to be affected by these rules; the department must also describe those efforts. Accordingly, the department must provide the following information in this statement of need and reasonableness pursuant to Minnesota Statutes, sections 14.131 and 14.23 and Minnesota Rules, part 1400.2070:

1.) a description of the classes of persons who probably will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule

The classes of persons affected by the rule are current and potential providers of rehabilitative and therapeutic services including physical and occupational therapy services, audiologists, speech-language pathologists, and the department.

The proposed amendments will benefit all current and potential providers of physical and occupational therapy services, audiologists, speech-language pathologists and the department by updating the rule language so that it reflect statutory, regulatory, and industry standards.

As Minnesota Rule, part 9505.0390 is presently written, the definitions do not reflect current industry standards and practices for the registration, accreditation, or certification of providers of rehabilitative and therapeutic services and need to be updated. The department also proposes to add language that states that providers of rehabilitative and therapeutic services must maintain an applicable state licensure or be in compliance with state regulatory requirements in states that do not license. It is reasonable and necessary to add this language to the rule because in Minnesota, providers of rehabilitative and therapeutic services are required to be licensed. However, the department also recognizes that not all states require licensure of these providers and Medical Assistance recipients may travel to states in which these providers are not required to be licensed. The language ensures that these providers are either licensed by the state in which they practice or in compliance with their state's regulatory requirements.

For Minnesota Rules, part 9505.0390 and 9505.0412, the department also suggests changing the 60 day review period for a recipient's plan of care to 90 days. Originally, when this language was added to the rule in 1991, the department justified the 60 day standard because 60 days was a common professional standard for making progress toward desired therapeutic goals. In 2008, 42 C.F.R. 485.711 was revised which specified the plan of care and physician involvement for outpatient physical therapy or speech pathology services. The regulation now states that the plan of care is to be reviewed by the physician or by the individual who established the plan at least as often as the patient's condition requires, and the indicated action is taken instead of every 30 days. The Centers for Medicare & Medicaid Services recommended in their

memorandum dated January 16, 2009 that the plan of care must be reviewed at least every 90 days. The department believes it is reasonable to apply a 90 day review period for a plan of care because this is consistent with industry practices.

Moreover, the department recommends editorial changes and changes to ensure the rule language reflects the most current state statutory and federal regulatory requirements The department suggests replacing the word "direction" with "supervision" because this is the terminology currently used in Minnesota Statutes, sections 148.6432 and 148.706 which define the supervision of occupational therapist assistance and physical therapy assistants, respectfully. Additionally, the department is replacing outdated rule language with the relevant federal regulation and state statutory citations that would allow the rule language to remain current without the need to change the rule periodically.

2.) the probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues;

The proposed amendments will benefit all current and potential providers of rehabilitative and therapeutic services and the department by updating and simplifying the rule language so that it reflect statutory, regulatory, and industry standards. There are no expected costs increases related to amending these rules. The proposed amendments will not affect state revenues.

3.) a determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule;

The department determined that amending the existing rule was the least costly and intrusive method to change, update, and maintain procedures for rehabilitative and therapeutic services.

4.) a description of any alternative methods for achieving the purpose of the proposed rule that were seriously considered by the agency and the reasons why they were rejected in favor of the proposed rule;

The department did not consider any other alternative methods for amending the rule language since these rules do not fall under any of the exempt exceptions under Minnesota statutes and cannot be included in the yearly obsolete rules report since these rules are not obsolete.

5.) the probable costs of complying with the proposed rule, including the portion of the total costs that will be borne by identifiable categories of affected parties, such as separate classes of governmental units, businesses, or individuals;

The proposed amendments will not result in additional costs to providers of physical and occupational therapy services, audiologists, speech-language pathologists or providers who employ these health care professionals.

The department is the only government unit affected because the department is the only government unit in the state that administers the medical assistance program.

6.) the probable costs or consequences of not adopting the proposed rule, including those costs or consequences borne by identifiable categories of affected parties, such as separate classes of government units, businesses, or individuals;

The consequences of not adopting the proposed amendments are:

As Minnesota Rules, parts 9505.0390, 9505.0391, and 9505.0412 are presently written, they are outdated and do not reflect current industry standards and practices for the registration, accreditation, or certification of providers of rehabilitative and therapeutic services. The department needs to update these rules to revise and incorporate the current qualifications for providers of rehabilitative and therapeutic services. Updating the rule will lead to consistent standards, practices, and reimbursement of providers.

7.) an assessment of any differences between the proposed rule and existing federal regulations and a specific analysis of the need for and reasonableness of each difference.

There is no difference between the proposed rule and the existing federal regulations.

8.) describe how the agency, in developing the rules, considered and implemented the legislative policy supporting performance-based regulatory systems set forth in section 14.002.

The proposed rule amendments are designed to lead to the consistent standards, practices, and reimbursement of providers of rehabilitative and therapeutic services.

As Minnesota Rule, part 9505.0390 is presently written, the definitions do not reflect current industry standards and practices for the registration, accreditation, or certification of providers of rehabilitative and therapeutic services. Additionally, the department needs more flexible rule language because federal and state laws and

regulations frequently change. Therefore, the department is replacing outdated rule language with the relevant federal regulation and state statutory citations that would allow the rule language to remain current without the need to change the rule periodically.

9.) a description of the department's efforts to provide additional notification under section 14.14, subdivision 1a, to persons or classes of persons who may be affected by the proposed rule or must explain why these efforts were not made.

The department's additional notice plan seeks to notify all persons and organizations who may be interested in the proposed rules that the department is able to identify through reasonable means. The department will notify those who have registered with the department to receive rulemaking notices. The department also intends to notify:

1) The Minnesota Occupational Therapy Association of Minnesota (MOTA)

2) The Minnesota Speech-Language Hearing Association (MSHA)

3) The Minnesota Chapter of American Physical Therapy Association (MNAPTA)

4) The Minnesota Academy of Audiology

5) The Vice President of Advocacy for Care Providers of Minnesota

6) Minnesota Disability Law Center, and

7) The Chair of the Minnesota State Bar Association's Health Law Section

8) All others who request notification

The department will also send a copy of all notices to be published in the State Register to all persons on the mailing list we compile. Along with the notice of hearing, the department will include a statement that a copy of the proposed rules will be sent to anyone who contacts the department for that purpose. Notice of the proposed rules and the statement of need and reasonableness will also be published on the department's Internet web site.

PROPOSED RULE CHANGES

Part 9505.0390, subpart 1, item A. "Audiologist". Part 9505.0390, subpart 1, item A. defines the term "audiologist" for this rule part. In the original 1991 statement of need and reasonableness (hereinafter 1991 SONAR) that promulgated this rule part, it stated that item A was, "...consistent with federal regulation and the language related to a person completing the clinical fellowship years and providing audiological services under supervision." The department needs to revise the definition in order to be in compliance with federal law. The department proposes to include language that refers directly to the federal regulation, 42 CFR 440.110, which defines "qualified audiologist" rather than restating the federal regulation definition. This will allow the state rule language to remain current and the department will not have to change the rule language periodically to reflect changes in federal regulation.

Part 9505.0390, subpart 1, item B. "Direction". Item B defines the word "direction" which means when a physical or occupational therapist can delegate specific duties to a physical therapist assistant or the occupational therapy assistant. The department proposes to change the name of this item from "Direction" to "Delegation of Duties" because state statutes that regulate the supervisor of physical therapist assistants or the occupational therapy assistants use the terminology "delegate" rather than direction. In accordance with this reasoning, the department proposes to delete the word "instruct" and replace it with "delegates."

Moreover, the department proposes to remove the language, "...provides on-site observation of the treatment and documentation of its appropriateness at least every sixth treatment session of each recipient" and replace it with the references to Minnesota Statutes, sections 148.6432 and 148.706 which define the supervision of occupational therapist assistants and physical therapy assistants, respectfully. By referring to the state statute, this would allow the state requirements to change without the need to change the rule periodically. The department also proposes to remove the reference to Minnesota Rules, parts 5601.1500 and 5601.1600 which were repealed in 2007.

Part 9505.0390, subpart 1, item D. "Occupational therapist." Part 9505.0390, subpart 1, item A. defines the term "occupational therapist" for this rule part. In the 1991 SONAR, the department stated that it used the same definition to define occupational therapist that was in the federal regulation. However, rather than repeat federal regulation, the department proposes to include language that refers directly to the federal regulation, 42 CFR 440.110, which defines "occupational therapist" rather than restating the federal regulation definition. By directly referring to the federal regulation, the department would not need to change the rule language periodically to reflect changes in the federal definition.

The department also proposes to add the language, "...and maintains applicable state licensure or is in compliance with state regulatory requirements in states that do not license." It is reasonable and necessary to add this language to the rule because in Minnesota, occupational therapists are required to be licensed. However, the department

also recognizes that not all states require licensure of occupational therapists and Medical Assistance recipients may travel to states in which occupational therapists are not required to be licensed. The language ensures that occupational therapists are either licensed by the state in which they practice or in compliance with their state's regulatory requirements.

Part 9505.0390, subpart 1, item E. "Occupational therapist assistant." Part 9505.0390, subpart 1, item E. defines the term "occupational therapist assistant" for this rule part. In the 1991 SONAR, the department chose to define this term in accordance with American Occupational Therapy Certification Board because it was the board that was comprised of persons who are aware of commonly accepted professional standards for occupational therapy. The definition is currently inaccurate, outdated, and incomplete. The American Occupational Therapy Certification Board (AOTA) no longer registers occupational therapists and has not for many years; instead, the National Board of Certification in Occupational Therapy administers the entry-level examination for both occupational therapists and occupational therapy assistants.

The department also proposes to add the language, "...and maintains applicable state licensure or is in compliance with state regulatory requirements in states that do not license." It is reasonable and necessary to add this language to the rule because in Minnesota, occupational therapist assistants are required to be licensed. However, the department also recognizes that not all states require licensure of occupational therapist assistants and Medical Assistance recipients may travel to states in which occupational therapist assistants are not required to be licensed. The language ensures that occupational therapist assistants are either licensed by the state in which they practice or in compliance with their state's regulatory requirements.

Part 9505.0390, subpart 1, item F. "Physical therapist." Part 9505.0390, subpart 1, item F. defines the term "physical therapist" for this rule part. The department seeks to remove the language that requires that physical therapists be a graduate of a program of physical therapy, "...approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association..." and replace it with, "...accredited by the Commission on Accreditation in Physical Therapy Education..." Currently, the Commission on Accreditation in Physical Therapy Education is the only accreditation agency recognized by the United States Department of Education (USDE) and the Council for Higher Education Accreditation (CHEA) to accredit entry-level physical therapist and physical therapist assistant education programs.[1] The Committee on Allied Health Education and Accreditation of the American Medical Association no longer accredits physical therapists.[2]

The department also seeks to add language requiring physical therapists to meet, "... the requirements of 42 CFR 440.110 and maintains applicable state licensure or is in compliance with state regulatory requirements in states that do not license." It is

---

[1] http://www.capteonline.org/Programs/
[2] http://www.caahep.org/Content.aspx?ID=14

reasonable to bring the rule language in conformity with Medical Assistance federal regulations that define physical therapists. The department also believes it is reasonable and necessary to add this language to the rule because in Minnesota, physical therapists are required to be licensed. However, the department also recognizes that not all states require licensure of physical therapists and Medical Assistance recipients may travel to states in which physical therapists are not required to be licensed. The language ensures that physical therapists are either licensed by the state in which they practice or in compliance with their state's regulatory requirements.

Part 9505.0390, subpart 1, item G. "Physical therapist assistant." Part 9505.0390, subpart 1, item G. defines the term "physical therapist assistant" for this rule part. The department proposes to strike the language, "...is qualified as specified in part 5601.0100, subpart 3" since Minnesota Rules, part 5601.0100, subpart 3 was repealed in 2005. (Minnesota Rules, part 5601.0100, subpart 3 previously defined physical therapy assistant.)

The department seeks to update this item of the rule with the following language, "...has successfully completed all academic and field work requirements of a physical therapist assistant program accredited by the Commission on Accreditation in Physical Therapy Education, and maintains applicable state licensure or is in compliance with state regulatory requirements in states that do not license."

It is reasonable to include language that requires physical therapist assistants to complete all academic and field work because this is a commonly accepted standard before an individual becomes a physical therapist assistant. Currently, the Commission on Accreditation in Physical Therapy Education is the only accreditation agency recognized by the United States Department of Education (USDE) and the Council for Higher Education Accreditation (CHEA) to accredit entry-level physical therapist and physical therapist assistant education programs.

The department also believes it is reasonable and necessary to add this language to the rule requiring physical therapist assistants to be licensed or be in compliance with their state's regulatory requirements if the state in which they practice does not license. In Minnesota, physical therapist assistants are required to be licensed. However, the department also recognizes that not all states require licensure of physical therapist assistants and Medical Assistance recipients may travel to states in which physical therapist assistants are not required to be licensed. The language ensures that physical therapist assistants are either licensed by the state in which they practice or in compliance with their state's regulatory requirements.

Part 9505.0390, subpart 1, item J. "Restorative therapy." Part 9505.0390, subpart 1, item J. defines the term "restorative therapy" for this rule part. For clarity, the department adds the word "certify" to identify the specific responsibilities of the physician or other licensed practitioner of the healing arts and the therapist to reflect actual practice standards. The therapist specifies the services needed in the plan of care (POC); the

physician or other licensed practitioner of the healing arts reviews and certifies the therapist's recommendation as defined in the POC. The way the language is written, it seems as if the physician or other licensed practitioner of the healing arts writes the POC, not the therapist.

Part 9505.0390, subpart 1, item K. "Specialized maintenance therapy." Part 9505.0390, subpart 1, item K. defines the term "specialized maintenance therapy" for this rule part. For clarity, the department adds the word "certify" to identify the specific responsibilities of the physician or other licensed practitioner of the healing arts and the therapist to reflect actual practice standards. The therapist specifies the services needed in the plan of care (POC); the physician or other licensed practitioner of the healing arts reviews and certifies the therapist's recommendation as defined in the POC. The way the language is written, it seems as if the physician or other licensed practitioner of the healing arts writes the POC, not the therapist.

Part 9505.0390, subpart 1, item L. "Speech-language pathologist." Part 9505.0390, subpart 1, item L. defines the term "speech-language pathologist" for this rule part. The department proposes to add the requirement that a speech-language pathologist is required to compete the clinical fellowship year which is required for certification as a speech-language pathologist. Moreover, the American Speech-Language-Hearing Association is the only organization that certifies speech-language pathologists.

The department also seeks to add the language requiring speech-language pathologists to meet, "... the requirements of 42 CFR 440.110 and maintains applicable state licensure or is in compliance with state regulatory requirements in states that do not license." It is reasonable to bring the rule language in conformance with Medical Assistance federal regulations that define speech-language pathologists. The department also believes it is reasonable and necessary to add this language to the rule because in Minnesota, speech-language pathologists are required to be licensed. However, the department also recognizes that not all states require licensure of speech-language pathologists and Medical Assistance recipients may travel to states in which speech-language pathologists are not required to be licensed. The language ensures that speech-language pathologists are either licensed by the state in which they practice or in compliance with their state's regulatory requirements.

Part 9505.0390, subpart 2, item B. Covered service; occupational therapy and physical therapy. Subpart 2 sets standards to be eligible for medical assistance payment for occupational and physical therapy provided to a recipient. Item B states that services are to be provided by a physical or occupational therapist or by a physical therapist assistant or occupational therapy assistant who, as appropriate, is under the direction of a physical or occupational therapist.

The department suggests replacing the word "direction" with "supervision" because this is the terminology currently used in Minnesota Statutes, sections 148.6432 and 148.706

which define the supervision of occupational therapist assistants and physical therapy assistants, respectfully.

The department also adds the language, "...as defined in part 9505.0390, subpart 1, items D, E, F, and G" to describe which occupational therapists, physical therapists, physical therapist assistants, and occupational therapy assistants can provide occupational therapy and physical therapy services. Subpart 2 defines coverage for occupational and physical therapy and this type of service must be provided by the providers (occupational therapists, physical therapists, physical therapist assistants, and occupational therapy assistants) defined in subpart 1 in order to be eligible for payment under Medical Assistance. It is reasonable to add this language to the rule because the department needs to ensure that services will be reimbursed by Medical Assistance.

Part 9505.0390, subpart 2, item C. Covered service; occupational therapy and physical therapy. Item C states that the recipient's functional status is expected to progress toward or achieve the objectives in the recipient's plan of care within a 60 day period. The department suggests changing the 60 day period to 90 days. Originally, when this language was added to the rule in 1991, the department justified the 60 day standard because 60 days was a common professional standard for making progress toward desired therapeutic goals. Additionally, the department applied Medicare standards in regulations (where there previously were not any standards or regulations for the Medical Assistance program) because use of federal standards assured at least a minimum level of quality. Moreover, the department stated that many recipients were eligible for both Medical Assistance and Medicare and emphasized maximizing federal financial participation (Medicare) as required under Minnesota statutes, section 256B.04, subdivision 4, while at the same time it wanted to safeguard against excess Medical Assistance payments as required under Minnesota Statutes, section 256B.04, subdivision 15.

In 2008, 42 C.F.R. 485.711 was revised which specified the plan of care and physician involvement for outpatient physical therapy or speech pathology services. The regulation now states that the plan of care is to be reviewed by the physician or by the individual who established the plan at least as often as the patient's condition requires, and the indicated action is taken instead of every 30 days. The Centers for Medicare & Medicaid Services recommended in their memorandum dated January 16, 2009 that the plan of care must be reviewed at least every 90 days.

The department believes it is reasonable to apply a 90 day review period for a plan of care because this is consistent with industry practices.

Part 9505.0390, subpart 2, item D. Covered service; occupational therapy and physical therapy Item D states how often the plan of care should be reviewed. Moreover, if the recipient is eligible for Medicare, item D states that the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare.

The department suggests changing the 60 day period to 90 days because 90 days is a professional and regulatory standard for physician plan of care review (See rationale for Part 9505.0390, subpart 2, item C. Covered service; occupational therapy and physical therapy, on page 12).

The department also proposes removing the language that states that Medicare eligible recipients must have their plan of care be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare and replacing it with the federal regulation citation that specifies the physician's involvement with the plan of care and how often it should be reviewed.

The language about having a recipient's plan of care reviewed at regular intervals was added to be compliant with federal regulation at the time it was written. However, federal regulations and Medicare standards and practices change over time. Instead of having rigid language that repeats federal regulations which may change, the department proposes referring to the actual federal regulation, 42 C.F.R. § 485.711, which specifies the recipient's plan of care and physician involvement for outpatient physical therapy or speech pathology services in order to be reimbursed by Medicare.

Part 9505.0390, subpart 3, item B. Covered service; speech-language service. Subpart 3 establishes medical assistance payment standards for speech-language pathology as a rehabilitative and therapeutic service. Item B states that the service must be provided by a speech-language pathologist.

The department proposes adding the language, "...as defined in part 9505.0390, subpart 1, item L" to describe which speech-language pathologists can provide speech-language services. Subpart 3 defines coverage for speech-language services and this type of service must be provided by the providers, speech-language pathologists, defined in subpart 1 in order to be eligible for payment under Medical Assistance. It is reasonable to add this language to the rule because the department needs to ensure that services will be reimbursed by Medical Assistance.

The department recommends deleting the language, "A person completing the clinical fellowship year required for certification as a speech-language pathologist may provide speech-language services under the supervision of a speech-language pathologist as specified in Minnesota Statutes, section 148.515, subdivision 4, but shall not be eligible to be enrolled as a provider under part 9505.0195." This language was originally added in 1991 to comply with federal regulation 42 CFR 440.110 (c) (2) which set standards for qualified speech pathologists. However, the standards described in the rule are no longer in the regulations.

Part 9505.0390, subpart 3, item C. Covered service; speech-language service. Item C states that a physician or licensed practitioners of the healing arts must state that they

believe a recipient's status must progress towards or achieve the objectives in the recipient's plan of care within a 60 day period.

The department suggests changing the 60 day period to 90 days because 90 days is a professional and regulatory standard for physician plan of care review (See rationale for Part 9505.0390, subpart 2, item C. Covered service; occupational therapy and physical therapy, on page 12).

Part 9505.0390, subpart 3, item D. Covered service; speech-language service. Item D states that the plan of care must be reviewed and revised by the recipient's physician or licensed practitioner of the healing arts at least once every 60 days. If the service covered is a Medicare covered service, the plan must be reviewed at intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare.

The department suggests changing the 60 day period to 90 days because 90 days is a professional and regulatory standard for physician plan of care review (See rationale for Part 9505.0390, subpart 2, item C. Covered service; occupational therapy and physical therapy, on page 12).

The department also proposes removing the language that states that Medicare eligible recipients must have their plan of care be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare and replacing it with the federal regulation citation that specifies the physician's involvement with the plan of care and how often it should be reviewed.

The language about having a recipient's plan of care reviewed at regular intervals was added to be compliant with federal regulation at the time it was written. However, federal regulations and Medicare standards and practices change over time. Instead of having rigid language that repeats federal regulations which may change, the department proposes referring to the actual federal regulation, 42 C.F.R. § 485.711, which specifies the recipient's plan of care and physician involvement for outpatient physical therapy or speech pathology services in order to reimbursed for Medicare.

Part 9505.0390, subpart 4, item B. Covered service; audiology. Subpart 4 sets standards to receive medical assistance payments for audiology services provided as a rehabilitative and therapeutic service in order to administer the medical assistance program. Item B states that the service must be performed by an audiologist.

The department proposes adding the language, "...as defined in part 9505.0390, subpart 1, item A" to describe which audiologists can provide audiology services. Subparts 4 defines coverage for audiology services and this type of service must be provided by the providers, audiologists, defined in subpart 1 in order to be eligible for payment under Medical Assistance. It is reasonable to add this language to the rule because the department needs to ensure that services will be reimbursed by Medical Assistance.

The department recommends deleting the language, "A person completing the clinical fellowship year required for certification as an audiologist may provide audiology services under the supervision of an audiologist but shall not be enrolled as a provider under part 9505.0195." This language was originally added in 1991 to comply with federal regulation 42 CFR 440.110 (c) (2) which set standards for qualified audiologists. However, the standards described in the rule are no longer in the regulations.

Part 9505.0390, subpart 4, item C. Covered service; audiology. Item C states that the plan of care must be reviewed and revised by the recipient's physician or licensed practitioner of the healing arts at least once every 60 days.

The department suggests changing the 60 day period to 90 days because 90 days is a professional and regulatory standard for physician plan of care review (See rationale for Part 9505.0390, subpart 2, item C. Covered service; occupational therapy and physical therapy, on page 12).

Part 9505.0390, subpart 4, item D. Covered service; audiology. Item D tried to balance three statutory and regulatory requirements that were in place at the time this rule item was enacted: 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.

The department suggests changing the 60 day period to 90 days because 90 days is a professional and regulatory standard for physician plan of care review (See rationale for Part 9505.0390, subpart 2, item C. Covered service; occupational therapy and physical therapy, on page 12).

The department also proposes removing the language that states that Medicare eligible recipients must have their plan of care be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare and replacing it with the federal regulation citation that specifies the physician's involvement with the plan of care and how often it should be reviewed.

The language about having a recipient's plan of care reviewed at regular intervals was added to be compliant with federal regulation at the time it was written. However, federal regulations and Medicare standards and practices change over time. Instead of having rigid language that repeats federal regulations which may change, the department proposes referring to the actual federal regulation, 42 C.F.R. § 485.711, which specifies the recipient's plan of care and physician involvement for outpatient physical therapy or speech pathology services in order to be reimbursed for Medicare.

Part 9505.0390, subpart 5, item B. Covered service; specialized maintenance therapy. Subpart 5 sets standards for medical assistance payment for specialized maintenance therapy. Item B tried to balance three statutory and regulatory requirements that were in place at the time this rule item was enacted: 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.

The department suggests changing the 60 day period to 90 days because 90 days is a professional and regulatory standard for physician plan of care review (See rationale for Part 9505.0390, subpart 2, item C. Covered service; occupational therapy and physical therapy, on page 12).

Part 9505.0390, subpart 7. Payment limitation; therapy assistants and aides. Subpart 7 specifies a medical assistance payment limitation applicable to services provided by physical or occupational therapy assistants or aids. The department proposes to add the word "delegated" to describe the services provided by therapy assistants because state statutes that regulate the supervisor of physical therapist assistants or the occupational therapy assistants use the terminology, "delegate." In accordance with this reasoning, the department proposes to add the word delegated.

Also, the department suggests replacing the word "direction" with "supervision" because this is the terminology currently used in Minnesota Statutes, sections 148.6432 and 148.706 which define the supervision of occupational therapist assistants and physical therapy assistants, respectfully.

Part 9505.0391. Therapists eligible to enroll as providers. This rule part was last amended in 2008. The department made the rule consistent with the current Code of Federal Regulations and U.S. Department of Health and Human Services Health Care Financing Administration's (hereinafter HCFA) practices and to removed language that acted as an unnecessary barrier to the enrollment of qualified therapists. At the time this rule part was amended, speech-language pathologists and audiologists were not allowed to enroll in Medicare. However, now speech-language pathologists and audiologists may enroll and submit claims directly to Medicare.[3]

[3] Section 80.3.Audiology Services, Section C. Coverage and Payment for Audiology Services and Section 80.3.1 - Definition of Qualified Audiologist of the Medicare Benefits Policy Manual defines what audiology services are covered by Medicare and who is considered a qualified audiologist for purposes of Medicare payment and coverage. Section 230.3 - Practice of Speech-Language Pathology of the Medicare Benefits Policy Manual defines what speech-language pathology services are covered by Medicare and who is considered a qualified speech-language pathologist for purposes of Medicare payment and coverage.

Part 9505.0412, item A. Required documentation of rehabilitative and therapeutic services. This part set standards applicable to all rehabilitative and therapeutic services regarding required recipient records.

The department suggests changing the 60 day period to 90 days because 90 days is a professional and regulatory standard for physician plan of care review (See rationale for Part 9505.0390, subpart 2, item C. Covered service; occupational therapy and physical therapy, on page 12).

The department also proposes removing the language that states that Medicare-eligible recipients must have their plan of care be reviewed at the intervals required by Medicare, and the recipient must be visited by the physician or by the physician delegate as required by Medicare, and replacing it with the federal regulation citation that specifies the physician's involvement with the plan of care and how often it should be reviewed.

The language about having a recipient's plan of care reviewed at regular intervals was added to be compliant with federal regulation at the time it was written. However, federal regulations and Medicare standards and practices change over time. Instead of having rigid language that repeats federal regulations which may change, the department proposes referring to the actual federal regulation, 42 C.F.R. § 485.711, which specifies the recipient's plan of care and physician involvement for outpatient physical therapy or speech pathology services in order to be reimbursed for Medicare.

Part 9505.0412, item B, subitem 1. Required documentation of rehabilitative and therapeutic services. Item B specifies the content of the plan of care. Subitem one states that the recipient's medical diagnosis, and any contraindications to treatment must be in the plan of care. The department proposes to add the language, "recipient's medical and treatment diagnosis" to the rule. The inclusion of the word "treatment" represents the standard of practice of the therapy disciplines. For example, the medical diagnosis for an individual might be diabetes but the reason the individual may need treatment (occupational therapy, physical therapy, or speech-language services) may be because the individual had a stroke. However, the way the rule is currently written, the reasons for the treatment would not need to be included in the plan of care- only the medical diagnosis. The diagnosis and the treatment may or may not be the same, depending on the patient's illness or injury. The documentation of the treatment diagnosis in the rule is a more accurate reflection of why the therapy was provided.

Part 9505.0412, item B, subitem C. Required documentation of rehabilitative and therapeutic services. Item B specifies that the plan of care must be signed by a physician. The department proposes to add the language, "or other licensed practitioner of the healing arts." to make this item consistent with the requirements of Minnesota Rules, part 9505.0390 which specifies that the plan of care must be signed by a physician or other licensed practitioner of the healing arts.

Part 9505.0412, item D, subitem 4. Required documentation of rehabilitative and therapeutic services. Item D 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. Subitem 4 says that a statement must be provided every 30 days by the therapist providing or supervising the services. The department proposes replacing the word "statement" with "documented evidence of progress." This change would bring the department in line with Medicare's practice. According to Medicare policy, a separate progress statement is not necessary if evidence of progress is in the therapist's treatment notes. This change would save providers from having to create a separate report when their treatment notes should already reflect the patient's progress.