

1 10A NCAC 22F .0301 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

2  
3 **SECTION .0300 - PROVIDER ABUSE**

4  
5 **10A NCAC 22F .0301 DEFINITION OF PROVIDER PROGRAM ABUSE BY PROVIDERS**

6 Provider abuse [Abuse, defined as provided by 42 C.F.R. 455.2, which is adopted and incorporated by reference with  
7 subsequent changes or amendments and available free of charge at <https://www.ecfr.gov/>] includes any Program  
8 abuse by providers as used in this Chapter consists of incidents, services, or practices inconsistent with accepted fiscal  
9 or medical practices which cause financial loss to the Medicaid program or its beneficiaries, or which are not  
10 reasonable or which are not necessary, including: necessary including, [includes] for example, the following:

- 11 (1) billing for care or services at a frequency or amount that is not medically necessary, as defined by  
12 10A NCAC 25A .0201; [overutilization] Overutilization of medical and health care and [services;]  
13 services.
- 14 (2) separate~~Separate~~ billing for care and services that are:
- 15 (a) part of an all-inclusive procedure; procedure, or
- 16 (b) included in the daily per-diem rate; rate.
- 17 (3) billing~~Billing~~ for care and services that are provided by an [unauthorized or] unlicensed person or  
18 person who does not meet the requirements set out in the Medicaid State Plan or Clinical Coverage  
19 Policies for the care or services, as allowed by law; [person;] person.
- 20 (4) failure to provide and maintain, within accepted medical standards for the community, quality of  
21 care;
- 22 (5)(4) failure~~Failure~~ to provide and maintain within accepted medical standards for the community, as set  
23 out in 10A NCAC 25A .0201, medically necessary care and services; [.0201:] community:
- 24 (a) proper quality of care,
- 25 (b) appropriate care and services, or
- 26 (c) medically necessary care and [services; or] services.
- 27 (6)(5) [breach] Breach of the terms and conditions of [the Provider Administrative Participation  
28 Agreement,] participation agreements, or a failure to comply with requirements of certification  
29 certification, or failure to comply with the terms and conditions for the submission of claims set out  
30 in Rule .0104(e) of this Subchapter; provisions of the claim form.
- 31 (7) abuse as defined by 42 C.F.R. 455.2, which is adopted and incorporated by reference with  
32 subsequent changes or amendments and available free of charge at <https://www.ecfr.gov/>;
- 33 (8) cause for termination as described in 42 C.F.R. 455.101, which is adopted and incorporated by  
34 reference with subsequent changes or amendments and available free of charge at  
35 <https://www.ecfr.gov/>;
- 36 (9) violations of State and federal Medicaid statutes, federal Medicaid regulations, the rules of this  
37 Subchapter, the State Medicaid Plan, and Medicaid Clinical Coverage policies;

- (10) failure to notify the Division of Health Benefits (Division) within 30 calendar days of learning of any adverse action initiated against any required license, certification, registration, accreditation, or endorsement of the provider or any of its officers, agents, or employees;
- (11) billing the Medicaid beneficiary or any other person for items and services reimbursed by the Division;
- (12) discounting client accounts to a third party agent or paying a third party agent a percentage of the amount collected;
- (13) failure to refund any monies received in error to the Division within 30 calendar days of discovery;
- (14) failure to file mandatory reports or required disclosures with the Division within the time-frames established in federal or state statute, rule, or regulation;
- (15) billing for claims that are inaccurate, incomplete, or not personally provided by the provider, its employees, or persons with whom the provider has contracted to render services, under its direction;
- (16) billing for services provided at or from a site location not associated with the approved provider number, except for hospital services as set forth in 42 C.F.R. 413.65;
- (17) failure to notify the Division in writing of any change in information contained in the Medicaid provider enrollment application within 30 calendar days of the event triggering the reporting obligation;
- (18) failure to retain or submit to the Division upon request documentation for services billed to the Division;
- (19) failure to grant the Division access to provider facilities upon the Division's request; or
- (20) failure to perform services or supply goods in accordance with all requirements under Title VI of the Civil Rights Act of 1964, Section 504 of the 1973 Rehabilitation Act, the 1975 Age Discrimination Act, the 1990 Americans With Disabilities Act, Section 1557 of the Affordable Care Act, and all applicable federal and state statutes, rules, and regulations relating to the protection of human subjects of research.

~~The foregoing examples do not restrict the meaning of the general definition.~~

*History Note:* Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 108A-54.2; 108A-63; 42 C.F.R. Part 455; 455-Subpart C;  
*Eff. April 15, 1977;*  
*Readopted Eff. October 31, 1977;*  
*Amended Eff. May 1, 1984; 1984.*  
*Readopted Eff. September 1, 2018.*

1 10A NCAC 22J .0106 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

2  
3 **10A NCAC 22J .0106 PROVIDER BILLING OF PATIENTS WHO ARE MEDICAID RECIPIENTS**

4 (a) A provider may refuse to accept a patient as a Medicaid patient and bill the patient as a private pay patient only if  
5 the provider informs the patient that the provider will not bill Medicaid for any services or supplies but will charge  
6 the patient for all services or supplies provided. If a provider refuses to accept a patient as a Medicaid patient, the  
7 provider shall inform the patient before providing any services or supplies, except when it would delay provision of  
8 an appropriate medical screening, medical examination, or treatment as required by 42 U.S.C. 1395dd.

9 (b) A provider will be deemed to have accepted ~~Acceptance of~~ a patient as a Medicaid patient ~~by a provider if the~~  
10 provider files a Medicaid claim for services or supplies provided to the patient. Verification of eligibility alone shall  
11 not be deemed acceptance of a patient as a Medicaid patient. includes, but is not limited to, entering the patient's  
12 Medicaid number or card into any sort of patient record or general record keeping system, obtaining other proof of  
13 Medicaid eligibility, or filing a Medicaid claim for services provided to a patient. A patient, or a patient's  
14 representative, must request acceptance as a Medicaid patient by:

- 15 (1) presenting the patient's Medicaid card or presenting a Medicaid number either orally or in writing;  
16 ~~or~~  
17 (2) stating either orally or in writing that the patient has Medicaid coverage; or  
18 (3) requesting acceptance of Medicaid upon approval of a pending application or a review of continuing  
19 eligibility.

20 (c) Providers may bill a patient accepted as a Medicaid patient only in the following situations:

- 21 (1) for allowable deductibles, co-insurance, or co-payments as specified in the Medicaid State Plan;  
22 ~~10A NCAC 22C .0102; or~~  
23 (2) before the service or supply is provided, provided the provider has informed the patient that the  
24 patient may be billed for a service or supply that is not one covered by Medicaid regardless of the  
25 type of provider or is beyond the limits of Medicaid coverage on Medicaid services as specified in  
26 the Medicaid State Plan or applicable clinical coverage policy promulgated pursuant to G.S. 108A-  
27 54.2(b); under 10A NCAC 22B, 10A NCAC 22C, and 10A NCAC 22D; or  
28 (3) the patient is 65 years of age or older and is enrolled in the Medicare program at the time services  
29 or supplies are received but has failed to supply a Medicare number as proof of coverage; or  
30 (4) the patient is not no longer eligible for Medicaid as defined in the Medicaid State Plan. ~~10A NCAC~~  
31 ~~24B.~~

32 (d) When a provider files a Medicaid claim for services or supplies provided to a Medicaid patient, the provider shall  
33 not bill the Medicaid patient for Medicaid services or supplies for which it receives no reimbursement from Medicaid  
34 when:

- 35 (1) the provider failed to follow program regulations; ~~or~~  
36 (2) the Division ~~agency~~ denied the claim on the basis of a lack of medical necessity; or

1 (3) the provider is attempting to bill the Medicaid patient beyond the situations stated in Paragraph (c)  
2 of this Rule.

3 (e) A provider who accepts a patient as a Medicaid patient shall agree to accept Medicaid ~~payment~~, ~~payment~~ plus any  
4 authorized deductible, co-insurance, ~~co-payment~~, ~~co-payment~~ and third party payment as payment in full for all  
5 Medicaid covered services **or supplies** provided, except that a provider shall ~~may~~ not deny services **or supplies** to any  
6 Medicaid patient on account of the individual's inability to pay a deductible, ~~co-insurance~~, ~~co-insurance~~ or co-payment  
7 amount as specified in the Medicaid State Plan. ~~10A NCAC 22C .0102~~. An individual's inability to pay shall not  
8 eliminate his or her liability for the cost sharing charge. Notwithstanding anything contained in this Paragraph, a  
9 provider may ~~actively~~ pursue recovery of third party funds that are primary to Medicaid.

10 (f) When a provider accepts a private patient, bills the private patient personally for Medicaid services **or supplies**  
11 covered under Medicaid for Medicaid recipients, and the patient is later found to be retroactively eligible for Medicaid,  
12 the provider may file for reimbursement with Medicaid. Upon receipt of Medicaid reimbursement, the provider shall  
13 refund to the patient all money paid by the patient for the services **or supplies** covered by Medicaid with the exception  
14 of any third party payments or cost sharing amounts as described in the Medicaid State Plan. ~~10A NCAC 22C .0102~~.

15  
16 *History Note: Authority G.S. 108A-25(b); 108A-54; **108A-54.1B**; 108A-54.2; ~~150B-11~~; 42 C.F.R. 447.15; 42*  
17 *C.F.R. 447.52(e); 42 C.F.R. 433.139;*  
18 *Eff. January 1, 1988;*  
19 *Amended Eff. February 1, 1996; October 1, 1994; ~~1994~~.*  
20 *Readopted Eff. September 1, 2018.*  
21  
22



STATE OF NORTH CAROLINA  
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October 1, 2018

Virginia Niehaus, Rulemaking Coordinator  
NC Department of Health and Human Services – Division of Medical Assistance  
**Sent via email only: [virginia.niehaus@dhhs.nc.gov](mailto:virginia.niehaus@dhhs.nc.gov)**

Re: Objection to Rules 10A NCAC 22F .0301 and 22J .0106

Dear Ms. Niehaus:

At its meeting on June 14, 2018, the Rules Review Commission objected to 10A NCAC 22F .0301 and 22J .0106 in accordance with G.S. 150B-21.10. At its meeting on August 16, 2018, the Rules Review Commission reviewed rewritten rules submitted by the Division in response to the June 14, 2018 objections. At that time, the Rules Review Commission objected to 10A NCAC 22F .0301 on the basis of ambiguity and continued their objection to 10A NCAC 22J .0106, finding that the rewritten rule had not met their objection. At their September 20, 2018 meeting, the Rules Review Commission continued their objections to both 10A NCAC 22F .0301 and 22J .0106.

Please respond to this letter in accordance with the provisions of G.S. 150B-21.12. If you have any questions regarding the Commission's actions, please feel free to contact me.

Sincerely,

Amber May  
Commission Counsel

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1 10A NCAC 22J .0106 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

2

3 **10A NCAC 22J .0106 PROVIDER BILLING OF PATIENTS WHO ARE MEDICAID RECIPIENTS**

4 (a) A provider may refuse to accept a patient as a Medicaid patient and bill the patient as a private pay patient only if  
5 the provider informs the patient that the provider will not bill Medicaid for any services but will charge the patient for  
6 all services provided.

7 (b) Acceptance of a patient as a Medicaid patient by a provider includes, but is not limited to, entering the patient's  
8 Medicaid number or card into any sort of patient record or general record-keeping system, obtaining other proof of  
9 Medicaid eligibility, or filing a Medicaid claim for services provided to a patient. A patient, or a patient's  
10 representative, must request acceptance as a Medicaid patient by:

- 11 (1) presenting the patient's Medicaid card or presenting a Medicaid number either orally or in writing;  
12 ~~or~~  
13 (2) stating either orally or in writing that the patient has Medicaid coverage; or  
14 (3) requesting acceptance of Medicaid upon approval of a pending application or a review of continuing  
15 eligibility.

16 (c) Providers may bill a patient accepted as a Medicaid patient only in the following situations:

- 17 (1) for allowable deductibles, co-insurance, or co-payments as specified in the Medicaid State Plan;  
18 ~~10A NCAC 22C .0102; or~~  
19 (2) before the service is provided the provider has informed the patient that the patient may be billed  
20 for a service that is not one covered by Medicaid regardless of the type of provider or is beyond the  
21 limits on Medicaid services as specified in the Medicaid State Plan or applicable clinical coverage  
22 policy promulgated pursuant to G.S. 108A-54.2(b); under 10A NCAC 22B, 10A NCAC 22C, and  
23 ~~10A NCAC 22D; or~~  
24 (3) the patient is 65 years of age or older and is enrolled in the Medicare program at the time services  
25 are received but has failed to supply a Medicare number as proof of coverage; or  
26 (4) the patient is not no longer eligible for Medicaid as defined in the Medicaid State Plan. ~~10A NCAC~~  
27 ~~21B.~~

28 (d) When a provider files a Medicaid claim for services provided to a Medicaid patient, the provider shall not bill the  
29 Medicaid patient for Medicaid services for which it receives no reimbursement from Medicaid when:

- 30 (1) the provider failed to follow program regulations; ~~or~~  
31 (2) the Division ~~agency~~ denied the claim on the basis of a lack of medical necessity; or  
32 (3) the provider is attempting to bill the Medicaid patient beyond the situations stated in Paragraph (c)  
33 of this Rule.

34 (e) A provider who accepts a patient as a Medicaid patient shall agree to accept Medicaid payment, ~~payment~~ plus any  
35 authorized deductible, co-insurance, co-payment, ~~co-payment~~ and third party payment as payment in full for all  
36 Medicaid covered services provided, except that a provider shall ~~may~~ not deny services to any Medicaid patient on  
37 account of the individual's inability to pay a deductible, co-insurance, ~~co-insurance~~ or co-payment amount as specified

1 in ~~the Medicaid State Plan. 10A NCAC 22C .0102.~~ An individual's inability to pay shall not eliminate his or her  
2 liability for the cost sharing charge. Notwithstanding anything contained in this Paragraph, a provider may ~~actively~~  
3 pursue recovery of third party funds that are primary to Medicaid.

4 (f) When a provider accepts a private patient, bills the private patient personally for Medicaid services covered under  
5 Medicaid for Medicaid recipients, and the patient is later found to be retroactively eligible for Medicaid, the provider  
6 may file for reimbursement with Medicaid. Upon receipt of Medicaid reimbursement, the provider shall refund to the  
7 patient all money paid by the patient for the services covered by Medicaid with the exception of any third party  
8 payments or cost sharing amounts as described in ~~the Medicaid State Plan. 10A NCAC 22C .0102.~~

9

10 *History Note:* Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 108A-54.2; ~~150B-11~~; 42 C.F.R. 447.15; 42  
11 C.F.R. 447.52(e); 42 C.F.R. 433.139;

12 *Eff. January 1, 1988;*

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14 *Readopted Eff. October 1, 2018.*

15

16



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August 21, 2018

Virginia Niehaus, Rulemaking Coordinator  
NC Department of Health and Human Services – Division of Medical Assistance  
**Sent via email only: [virginia.niehaus@dhhs.nc.gov](mailto:virginia.niehaus@dhhs.nc.gov)**

Re: Objection to Rules 10A NCAC 22F .0301 and 22J .0106

Dear Ms. Niehaus:

At its meeting on June 14, 2018, the Rules Review Commission objected to 10A NCAC 22F .0104, .0301, .0302, .0602, .0603, .0604, and 22J .0105 and .0106 in accordance with G.S. 150B-21.10. At its meeting on August 16, 2018, the Rules Review Commission reviewed rewritten rules submitted by the Division in response to the June 14, 2018 objections. At that time, the Rules Review Commission objected to 10A NCAC 22F .0301 on the basis of ambiguity and continued their objection to 10A NCAC 22J .0106, finding that the rewritten rule had not met their objection. They approved all other rules.

Please respond to this letter in accordance with the provisions of G.S. 150B-21.12. If you have any questions regarding the Commission's actions, please feel free to contact me.

Sincerely,

Amber May  
Commission Counsel

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1 10A NCAC 22F .0301 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

2  
3 **SECTION .0300 - PROVIDER ABUSE**

4  
5 **10A NCAC 22F .0301 DEFINITION OF PROVIDER PROGRAM ABUSE BY PROVIDERS**

6 Provider abuse [Abuse, defined as provided by 42 C.F.R. 455.2, which is adopted and incorporated by reference with  
7 subsequent changes or amendments and available free of charge at <https://www.ecfr.gov/>] includes any incidents,  
8 services, or practices inconsistent with accepted fiscal or medical practices which cause financial loss to the Medicaid  
9 program or its beneficiaries, or which are not reasonable or which are not necessary including, [includes] for example,  
10 the following: Program abuse by providers as used in this Chapter includes:

- 11 (1) billing for care or services at a frequency or amount that is not medically necessary, as defined by  
12 10A NCAC 25A .0201; ~~[overutilization]~~ Overutilization of medical and health care and ~~[services];~~  
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18 person who does not meet the requirements set out in the Medicaid State Plan or Clinical Coverage  
19 Policies for the care or services, as allowed by law; ~~[person;]~~ person.
- 20 (4) failure ~~Failure~~ to provide and maintain within accepted medical standards for the community, as set  
21 out in 10A NCAC 25A .0201; ~~community;~~
  - 22 (a) proper ~~proper~~ quality of care; or care,
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  - 24 ~~(c)~~ (b) medically necessary care and ~~services; [or]~~ services.
- 25 (5) breach ~~Breach~~ of the terms and conditions of the Provider Administrative Participation Agreement,  
26 participation agreements, or a failure to comply with requirements of certification, or failure to  
27 comply with the terms and conditions for the submission of claims set out in Rule .0104(e) of this  
28 Subchapter; ~~provisions of the claim form.~~
- 29 (6) abuse as defined by 42 C.F.R. 455.2, which is adopted and incorporated by reference with  
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- 31 (7) cause for termination as described in 42 C.F.R. 455.101, which is adopted and incorporated by  
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33 <https://www.ecfr.gov/>; or
- 34 (8) violations of State and federal Medicaid statutes, federal Medicaid regulations, the rules of this  
35 Subchapter, the State Medicaid Plan, and Medicaid Clinical Coverage policies.

36 The foregoing examples do not restrict the meaning of the general definition.  
37

1 *History Note:* Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 108A-54.2; 108A-63; 42 C.F.R. Part 455; 455,  
2 ~~Subpart C;~~  
3 *Eff. April 15, 1977;*  
4 *Readopted Eff. October 31, 1977;*  
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24 patient may be billed for a service or supply that is not one covered by Medicaid regardless of the  
25 type of provider or is beyond the limits of Medicaid coverage on Medicaid services as specified in  
26 the Medicaid State Plan or applicable clinical coverage policy promulgated pursuant to G.S. 108A-  
27 54.2(b); under 10A NCAC 22B, 10A NCAC 22C, and 10A NCAC 22D; or  
28 (3) the patient is 65 years of age or older and is enrolled in the Medicare program at the time services  
29 or supplies are received but has failed to supply a Medicare number as proof of coverage; or  
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33 not bill the Medicaid patient for Medicaid services or supplies for which it receives no reimbursement from Medicaid  
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16 *History Note: Authority G.S. 108A-25(b); 108A-54; **108A-54.1B**; 108A-54.2; ~~150B-11~~; 42 C.F.R. 447.15; 42*  
17 *C.F.R. 447.52(e); 42 C.F.R. 433.139;*  
18 *Eff. January 1, 1988;*  
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June 21, 2018

Virginia Niehaus, Rulemaking Coordinator  
NC Department of Health and Human Services – Division of Medical Assistance  
**Sent via email only: [virginia.niehaus@dhhs.nc.gov](mailto:virginia.niehaus@dhhs.nc.gov)**

Re: Objection to Rules 10A NCAC 22F .0104, .0301, .0302, .0602, .0603, .0604, and 22J .0105 and .0106.

Dear Ms. Niehaus:

At its meeting on June 14, 2018, the Rules Review Commission objected to the above referenced Rules in accordance with G.S. 150B-21.10.

The Commission objected to 10A NCAC 22F .0104 for lack of statutory authority and ambiguity in Subparagraph (e)(6).

The Commission objected to 10A NCAC 22F .0301 for lack of statutory authority and necessity.

The Commission objected to 10A NCAC 22F .0302 for lack of statutory authority regarding Subparagraph (c)(1).

The Commission objected to 10A NCAC 22F .0602 for lack of statutory authority regarding Subparagraph (a)(3).

The Commission objected to 10A NCAC 22F .0603 for lack of authority and ambiguity in Subparagraph (a)(2).

The Commission objected to 10A NCAC 22F .0604 for necessity regarding Paragraph (b).

The Commission objected to 10A NCAC 22J .0105 for lack of statutory authority regarding the recoupment of an overpayment prior to the exhaustion of all appeal rights.

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fax: 919/431-3104

Civil Rights  
Division  
919/431-3036  
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The Commission objected to 10A NCAC 22J .0106 for lack of statutory authority regarding Subparagraphs (c)(2) and (c)(4).

Please respond to this letter in accordance with the provisions of G.S. 150B-21.12. If you have any questions regarding the Commission's actions, please feel free to contact me.

Sincerely,



Amber May  
Commission Counsel

1 10A NCAC 22F .0301 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

2  
3 **SECTION .0300 - PROVIDER ABUSE**

4  
5 **10A NCAC 22F .0301 DEFINITION OF PROVIDER ABUSE**

6 Provider abuse Abuse, defined as provided by 42 C.F.R. 455.2, which is adopted and incorporated by reference with  
7 subsequent changes or amendments and available free of charge at <https://www.ecfr.gov/>, ~~includes any incidents,~~  
8 services, or practices inconsistent with accepted fiscal or medical practices which cause financial loss to the Medicaid  
9 program or its beneficiaries, or which are not reasonable or which are not necessary including, includes for example,  
10 the ~~abuses by providers: following:~~

- 11 (1) billing for care or services at a frequency or amount that is not medically necessary, as defined by  
12 10A NCAC 25A .0201; ~~[overutilization]~~ Overutilization of medical and health care and ~~[services];~~  
13 services.
- 14 (2) separate~~Separate~~ billing for care and services that are:
- 15 (a) part of an all-inclusive procedure; procedure, or
- 16 (b) included in the daily per-diem rate; rate.
- 17 (3) billing~~Billing~~ for care and services that are provided by an ~~[unauthorized or]~~ unlicensed person or  
18 person who does not meet the requirements set out in the Medicaid State Plan or Clinical Coverage  
19 Policies for the care or services; ~~[person;]~~ person.
- 20 (4) failure~~Failure~~ to provide and maintain within accepted medical standards for the community, as set  
21 out in 10A NCAC 25A .0201, including: ~~[-0201:]~~ community:
- 22 (a) proper ~~quality of care; or care,~~
- 23 (b) ~~appropriate care and services, or~~
- 24 (c) medically necessary care and services; or services.
- 25 (5) breach~~Breach~~ of the terms and conditions of the Provider Administrative Participation Agreement,  
26 participation agreements, or a failure to comply with requirements of certification, or failure to  
27 comply with the terms and conditions for the submission of claims set out in Rule .0104(e) of this  
28 Subchapter. provisions of the claim form.

29 ~~The foregoing examples do not restrict the meaning of the general definition.~~

30  
31 *History Note: Authority G.S. 108A-25(b); 108A-54.2; 108A-63; 42 C.F.R. Part 455; 455, Subpart C;*  
32 *Eff. April 15, 1977;*  
33 *Readopted Eff. October 31, 1977;*  
34 *Amended Eff. May 1, 1984; 1984.*  
35 *Readopted Eff. July 1, 2018.*

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0301

**DEADLINE FOR RECEIPT: Friday, June 8, 2018**

***PLEASE NOTE: This request may extend to several pages. Please be sure you have reached the end of the document.***

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

*I realize that you all deleted “provider abuse” because that is not what is defined by 42 CFR 455.2, but please make it clear within the body of the text of the rule that this is referring to provider abuse.*

*It looks like in your investigations rules, you have removed “overutilization”; however, you have kept it in (1). Was this intentional?*

*In (1), what is considered “overutilization”? I assume that this is set forth elsewhere in rule, statute, or the Plan?*

*Please change the comma at the end of (2)(a) to a semi-colon.*

*In (3), who is an “unauthorized” person? Is this set forth in the contract between the provider?*

*(4) appears to be missing a lead in to the sub-items. Should there be an “including” or something of the like at the end?*

*Please end (4)(a) and (b) with semi-colons, rather than commas.*

*In (4)(a), please delete or define “proper”*

*In (4)(b), please delete or define “appropriate”*

*In (4)(c), please delete or define “medically necessary”*

*In (5), what are the requirements of certification? Are these set forth elsewhere?*

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May  
Commission Counsel  
Date submitted to agency: May 29, 2018

1 10A NCAC 22F .0301 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

2  
3 **SECTION .0300 - PROVIDER ABUSE**

4  
5 **10A NCAC 22F .0301 DEFINITION OF PROVIDER ABUSE**

6 ~~Provider abuse~~ Abuse, defined as provided by 42 C.F.R. 455.2, which is adopted and incorporated by reference with  
7 subsequent changes or amendments and available free of charge at <https://www.ecfr.gov/>, includes any incidents,  
8 ~~services, or practices inconsistent with accepted fiscal or medical practices which cause financial loss to the Medicaid~~  
9 ~~program or its beneficiaries, or which are not reasonable or which are not necessary including, includes for example,~~  
10 the following:

- 11 (1) ~~overutilization~~ Overutilization of medical and health care and ~~services; services.~~
- 12 (2) ~~separate~~ Separate billing for care and services that are:
- 13 (a) part of an all-inclusive procedure, or
- 14 (b) included in the daily per-diem rate; rate.
- 15 (3) ~~billing~~ Billing for care and services that are provided by an unauthorized or unlicensed person;  
16 ~~person.~~
- 17 (4) ~~failure~~ Failure to provide and maintain within accepted medical standards for the community, as set  
18 out in 10A NCAC 25A .0201; community;
- 19 (a) proper quality of care,
- 20 (b) appropriate care and services, or
- 21 (c) medically necessary care and services; or services.
- 22 (5) ~~breach~~ Breach of the terms and conditions of the Provider Administrative Participation Agreement,  
23 ~~participation agreements, or a failure to comply with requirements of certification, or failure to~~  
24 comply with the terms and conditions for the submission of claims set out in Rule .0104(e) of this  
25 Subchapter. provisions of the claim form.

26 ~~The foregoing examples do not restrict the meaning of the general definition.~~  
27

28 *History Note: Authority G.S. 108A-25(b); 108A-54.2; 108A-63; 42 C.F.R. Part 455; 455, Subpart C;*  
29 *Eff. April 15, 1977;*  
30 *Readopted Eff. October 31, 1977;*  
31 *Amended Eff. May 1, 1984; 1984.*  
32 *Readopted Eff. July 1, 2018.*  
33  
34

1 10A NCAC 22J .0106 is readopted as published in 32:13 NCR 1258–1268 as follows:

2

3 **10A NCAC 22J .0106 PROVIDER BILLING OF PATIENTS WHO ARE MEDICAID RECIPIENTS**

4 (a) A provider may refuse to accept a patient as a Medicaid patient and bill the patient as a private pay patient only if  
5 the provider informs the patient that the provider will not bill Medicaid for any services but will charge the patient for  
6 all services provided.

7 (b) Acceptance of a patient as a Medicaid patient by a provider includes, but is not limited to, entering the patient's  
8 Medicaid number or card into any sort of patient record or general record-keeping system, obtaining other proof of  
9 Medicaid eligibility, or filing a Medicaid claim for services provided to a patient. A patient, or a patient's  
10 representative, must request acceptance as a Medicaid patient by:

- 11 (1) presenting the patient's Medicaid card or presenting a Medicaid number either orally or in writing;  
12 ~~or~~  
13 (2) stating either orally or in writing that the patient has Medicaid coverage; or  
14 (3) requesting acceptance of Medicaid upon approval of a pending application or a review of continuing  
15 eligibility.

16 (c) Providers may bill a patient accepted as a Medicaid patient only in the following situations:

- 17 (1) for allowable deductibles, co-insurance, or co-payments as specified in the Medicaid State Plan;  
18 ~~10A NCAC 22C .0102; or~~  
19 (2) before the service is provided the provider has informed the patient that the patient may be billed  
20 for a service that is not one covered by Medicaid regardless of the type of provider or is beyond the  
21 limits on Medicaid services as specified in the Medicaid State Plan or applicable clinical coverage  
22 policy promulgated pursuant to G.S. 108A-54.2(b); under 10A NCAC 22B, 10A NCAC 22C, and  
23 ~~10A NCAC 22D; or~~  
24 (3) the patient is 65 years of age or older and is enrolled in the Medicare program at the time services  
25 are received but has failed to supply a Medicare number as proof of coverage; or  
26 (4) the patient is no longer eligible for Medicaid as defined in the Medicaid State Plan. ~~10A NCAC~~  
27 ~~21B.~~

28 (d) When a provider files a Medicaid claim for services provided to a Medicaid patient, the provider shall not bill the  
29 Medicaid patient for Medicaid services for which it receives no reimbursement from Medicaid when:

- 30 (1) the provider failed to follow program regulations; ~~or~~  
31 (2) the Division ~~agency~~ denied the claim on the basis of a lack of medical necessity; or  
32 (3) the provider is attempting to bill the Medicaid patient beyond the situations stated in Paragraph (c)  
33 of this Rule.

34 (e) A provider who accepts a patient as a Medicaid patient shall agree to accept Medicaid payment, ~~payment~~ plus any  
35 authorized deductible, co-insurance, co-payment, ~~co-payment~~ and third party payment as payment in full for all  
36 Medicaid covered services provided, except that a provider shall ~~may~~ not deny services to any Medicaid patient on  
37 account of the individual's inability to pay a deductible, co-insurance, ~~co-insurance~~ or co-payment amount as specified

1 in ~~the Medicaid State Plan, 10A NCAC 22C .0102.~~ An individual's inability to pay shall not eliminate his or her  
2 liability for the cost sharing charge. Notwithstanding anything contained in this Paragraph, a provider may actively  
3 pursue recovery of third party funds that are primary to Medicaid.

4 (f) When a provider accepts a private patient, bills the private patient personally for Medicaid services covered under  
5 Medicaid for Medicaid recipients, and the patient is later found to be retroactively eligible for Medicaid, the provider  
6 may file for reimbursement with Medicaid. Upon receipt of Medicaid reimbursement, the provider shall refund to the  
7 patient all money paid by the patient for the services covered by Medicaid with the exception of any third party  
8 payments or cost sharing amounts as described in ~~the Medicaid State Plan, 10A NCAC 22C .0102.~~

9  
10 *History Note:* Authority *G.S. 108A-25(b); 108A-54; 108A-54.2; ~~150B-11~~; 42 C.F.R. 447.15; 42 C.F.R. 447.52(e);*  
11 *42 C.F.R. 433.139;*  
12 *Eff. January 1, 1988;*  
13 *Amended Eff. February 1, 1996; October 1, 1994; ~~1994~~.*  
14 *Readopted Eff. July 1, 2018.*  
15  
16