# RRC STAFF OPINION

*PLEASE NOTE: THIS COMMUNICATION IS EITHER 1) ONLY THE RECOMMENDATION OF AN RRC STAFF ATTORNEY AS TO ACTION THAT THE ATTORNEY BELIEVES THE COMMISSION SHOULD TAKE ON THE CITED RULE AT ITS NEXT MEETING, OR 2) AN OPINION OF THAT ATTORNEY AS TO SOME MATTER CONCERNING THAT RULE. THE AGENCY AND MEMBERS OF THE PUBLIC ARE INVITED TO SUBMIT THEIR OWN COMMENTS AND RECOMMENDATIONS (ACCORDING TO RRC RULES) TO THE COMMISSION.*

AGENCY: Department of Health and Human Services/ Division of Medical Assistance (DHB)

RULE CITATION: 10A NCAC 22F .0301

RECOMMENDED ACTION:

Approve, but note staff's comment

Object, based on:

Lack of statutory authority

Unclear or ambiguous

Unnecessary

Failure to comply with the APA

Extend the period of review

X No action necessary

COMMENT:

This Rule was objected to by the RRC at the June 14, 2018, August 16, 2018, and September 20, 2018 meetings. At its November 15, 2018 meeting, this Rule was approved by the RRC, but the RRC found that the rewritten rule submitted in response to their objection resulted in substantial changes to the Rule as referenced in 150B-21.12(c). As such, this Rule must be "published and reviewed in accordance with the procedure set forth in G.S. 150B-21.1(a3) and (b).

There is no action for the RRC to take at this time.

Amber May
Commission Counsel

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

## SECTION .0300 - PROVIDER ABUSE

### 10A NCAC 22F .0301 DEFINITION OF ~~PROVIDER~~ PROGRAM ABUSE BY PROVIDERS

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

(1) billing for care or services at a frequency or amount that is not medically necessary, as defined by 10A NCAC 25A .0201; [~~overutilization~~] ~~Overutilization of medical and health care and~~ [~~services;~~] ~~services.~~

(2) separate~~Separate~~ billing for care and services that are:

(a) part of an all-inclusive procedure; ~~procedure,~~ or

(b) included in the daily per-diem rate; ~~rate.~~

(3) billing~~Billing~~ for care and services that are provided by an [~~unauthorized or~~] unlicensed person or person who does not meet the requirements set out in the Medicaid State Plan or Clinical Coverage Policies for the care or services, as allowed by law; [~~person;~~] ~~person.~~

(4) failure to provide and maintain, within accepted medical standards for the community, quality of care;

~~(5)~~~~(4)~~ failure~~Failure~~ to provide and maintain within accepted medical standards for the community, as set out in 10A NCAC 25A .0201, medically necessary care and services; [~~.0201:~~] ~~community:~~

~~(a) proper quality of care,~~

~~(b) appropriate care and services, or~~

~~(c) medically necessary care and~~ [~~services; or~~] ~~services.~~

~~(6)~~~~(5)~~ [~~breach~~]~~Breach~~ ~~of the terms and conditions of~~ [~~the Provider Administrative Participation Agreement,~~] ~~participation agreements, or a~~ failure to comply with requirements of certification ~~certification,~~ or failure to comply with the terms and conditions for the submission of claims set out in Rule .0104(e) of this Subchapter; ~~provisions of the claim form.~~

(7) abuse as defined by 42 C.F.R. 455.2, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/;

(8) cause for termination as described in 42 C.F.R. 455.101, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/;

(9) violations of State and federal Medicaid statutes, federal Medicaid regulations, the rules of this 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.*

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

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

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

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

(1) presenting the patient's Medicaid card or presenting a Medicaid number either orally or in writing; ~~or~~

(2) stating either orally or in writing that the patient has Medicaid coverage; or

(3) requesting acceptance of Medicaid upon approval of a pending application or a review of continuing eligibility.

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

(1) for allowable deductibles, co-insurance, or co-payments as specified in the Medicaid State Plan; ~~10A NCAC 22C .0102; or~~

(2) before the service or supply is provided, ~~provided~~ the provider has informed the patient that the patient may be billed for a service or supply that is not one covered by Medicaid regardless of the type of provider or is beyond the limits of Medicaid coverage ~~on Medicaid services~~ as specified in the Medicaid State Plan or applicable clinical coverage policy promulgated pursuant to G.S. 108A-54.2(b); ~~under 10A NCAC 22B, 10A NCAC 22C, and 10A NCAC 22D; or~~

(3) the patient is 65 years of age or older and is enrolled in the Medicare program at the time services or supplies are received but has failed to supply a Medicare number as proof of coverage; or

(4) the patient is not ~~no longer~~ eligible for Medicaid as defined in the Medicaid State Plan. ~~10A NCAC 21B.~~

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

(1) the provider failed to follow program regulations; ~~or~~

(2) the Division ~~agency~~ denied the claim on the basis of a lack of medical necessity; or

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

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

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

*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 C.F.R. 447.52(e); 42 C.F.R. 433.139;*
*Eff. January 1, 1988;*
*Amended Eff. February 1, 1996; October 1, 1994; ~~1994.~~*
*Readopted Eff. September 1, 2018.*

STATE OF NORTH CAROLINA
# OFFICE OF ADMINISTRATIVE HEARINGS

Mailing address:
6714 Mail Service Center
Raleigh, NC 27699-6700

Street address:
1711 New Hope Church Rd
Raleigh, NC 27609-6285

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**

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

STATE OF NORTH CAROLINA
**OFFICE OF ADMINISTRATIVE HEARINGS**

Mailing address:
6714 Mail Service Center
Raleigh, NC 27699-6700

Street address:
1711 New Hope Church Rd
Raleigh, NC 27609-6285

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**

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

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

## SECTION .0300 - PROVIDER ABUSE

### 10A NCAC 22F .0301 DEFINITION OF ~~PROVIDER~~ PROGRAM ABUSE BY PROVIDERS

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

(1) billing for care or services at a frequency or amount that is not medically necessary, as defined by 10A NCAC 25A .0201; [~~overutilization~~] ~~Overutilization of medical and health care and~~ [~~services;~~] ~~services.~~

(2) separate~~Separate~~ billing for care and services that are:

(a) part of an all-inclusive procedure; ~~procedure,~~ or

(b) included in the daily per-diem rate; ~~rate.~~

(3) billing~~Billing~~ for care and services that are provided by an [~~unauthorized or~~] unlicensed person or person who does not meet the requirements set out in the Medicaid State Plan or Clinical Coverage Policies for the care or services, as allowed by law; [~~person;~~] ~~person.~~

(4) failure~~Failure~~ to provide and maintain within accepted medical standards for the community, as set out in 10A NCAC 25A .0201: ~~community:~~

(a) ~~proper~~ quality of care; or ~~care,~~

~~(b) appropriate care and services, or~~

~~(c)~~(b) medically necessary care and services; [~~or~~] ~~services.~~

(5) breach~~Breach~~ of the terms and conditions of the Provider Administrative Participation Agreement, ~~participation agreements, or~~ a failure to comply with requirements of certification, or failure to comply with the terms and conditions for the submission of claims set out in Rule .0104(e) of this Subchapter; ~~provisions of the claim form.~~

(6) abuse as defined by 42 C.F.R. 455.2, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/;

(7) cause for termination as described in 42 C.F.R. 455.101, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/; or

(8) violations of State and federal Medicaid statutes, federal Medicaid regulations, the rules of this Subchapter, the State Medicaid Plan, and Medicaid Clinical Coverage policies.

~~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.*

STATE OF NORTH CAROLINA
# OFFICE OF ADMINISTRATIVE HEARINGS

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Street address:
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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**

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.

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

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

## SECTION .0300 - PROVIDER ABUSE

### 10A NCAC 22F .0301 DEFINITION OF PROVIDER ABUSE

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

(1) billing for care or services at a frequency or amount that is not medically necessary, as defined by 10A NCAC 25A .0201; [~~overutilization~~] ~~Overutilization of medical and health care and~~ [~~services;~~] ~~services.~~

(2) separate~~Separate~~ billing for care and services that are:

(a) part of an all-inclusive procedure; ~~procedure,~~ or

(b) included in the daily per-diem rate; ~~rate.~~

(3) billing~~Billing~~ for care and services that are provided by an [~~unauthorized or~~] unlicensed person or person who does not meet the requirements set out in the Medicaid State Plan or Clinical Coverage Policies for the care or services; [~~person;~~] ~~person.~~

(4) failure~~Failure~~ to provide and maintain within accepted medical standards for the community, as set out in 10A NCAC 25A .0201, including: [~~.0201:~~] ~~community:~~

(a) ~~proper~~ quality of care; or ~~care,~~

~~(b) appropriate care and services, or~~

~~(c)~~(b) medically necessary care and services; or ~~services.~~

(5) breach~~Breach~~ of the terms and conditions of the Provider Administrative Participation Agreement, ~~participation agreements, or~~ a failure to comply with requirements of certification, or failure to comply with the terms and conditions for the submission of claims set out in Rule .0104(e) of this Subchapter. ~~provisions of the claim form.~~

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

*History Note:* *Authority G.S. 108A-25(b); 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. 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

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

## SECTION .0300 - PROVIDER ABUSE

### 10A NCAC 22F .0301 DEFINITION OF PROVIDER ABUSE

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

(1) overutilization~~Overutilization~~ of ~~medical and~~ health care ~~and~~ services; ~~services.~~

(2) separate~~Separate~~ billing for care and services that are:

(a) part of an all-inclusive procedure, or

(b) included in the daily per-diem rate; ~~rate.~~

(3) billing~~Billing~~ for care and services that are provided by an unauthorized or unlicensed person; ~~person.~~

(4) failure~~Failure~~ to provide and maintain within accepted medical standards for the community, as set out in 10A NCAC 25A .0201: ~~community:~~

(a) proper quality of care,

(b) appropriate care and services, or

(c) medically necessary care and services; or ~~services.~~

(5) breach~~Breach~~ of the terms and conditions of the Provider Administrative Participation Agreement, ~~participation agreements, or~~ a failure to comply with requirements of certification, or failure to comply with the terms and conditions for the submission of claims set out in Rule .0104(e) of this Subchapter. ~~provisions of the claim form.~~

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

*History Note:* *Authority G.S. 108A-25(b); 108A-54.2; 108A-63; 42 C.F.R. Part 455; ~~455, Subpart C;~~*
*Eff. April 15, 1977;*
*Readopted Eff. October 31, 1977;*
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