10A NCAC 22F .0104 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0104 PREVENTION

(a) Provider Education. Upon the request of a provider, the ~~The~~ Division [~~may,~~] may ~~at its discretion, or shall upon the request of a provider,~~ conduct on-site educational visits to assist a provider in complying with requirements of the Medicaid Program.

(b) Provider Manuals. The Division shall ~~will~~ prepare and make available ~~furnish each provider with~~ a provider manual containing at least the following information:

(1) amount, duration, and scope of assistance;

(2) participation standards;

(3) penalties;

(4) reimbursement rules; and

(5) claims filing instructions.

(c) Prepayment Claims Review. The Division shall ~~will~~ check eligibility, duplicate payments, third party liability, and unauthorized or uncovered services by means of prepayment review, computer edits and audits, and investigation. ~~other appropriate methods of review.~~

(d) Prior Approval. The Division shall require prior approval for certain specified covered services as set forth in the Medicaid State Plan.

(e) Claims. ~~Claim Forms.~~ The following terms and conditions shall apply to the submission of claims: [~~Claim forms shall contain~~] ~~The Division's provider claim forms shall include the following requirements~~ [that] ~~for provider participation and payment. These requirements shall be binding~~ [~~on~~] ~~upon the Division and the providers:~~

(1) [~~medicaid~~]Medicaid payment shall constitute ~~constitutes~~ payment in full;~~full.~~

(2) charges~~Charges~~ to Medicaid recipients for the same items and services shall not be higher than for private paying patients;~~patients.~~

(3) the~~The~~ provider shall keep all records as necessary to support the services claimed for reimbursement;~~reimbursement.~~

(4) the~~The~~ provider shall ~~fully~~ disclose the contents of his Medicaid financial and medical records to the Division and its agents;~~agents.~~ and

(5) [~~medicaid~~]Medicaid reimbursement shall only be made for medically necessary care and services as defined in 10A NCAC 25A .0201. [~~.0201; and~~] ~~services.~~

~~(6) [the] The Division may suspend or terminate a provider for violations of Medicaid laws, [federal] regulations, [the rules of this Subchapter, the provider administrative participation agreement, the Medicaid State Plan, and Medicaid Clinical Coverage policies.] policies, or guidelines.~~

(f) ~~Pharmacy and Institutional~~ Provider Administrative Participation Agreements. All ~~institutional and pharmacy~~ providers shall ~~be required to~~ execute a written participation agreement as a condition for participating in the N.C. State Medicaid ~~Medical Assistance~~ Program.

(g) The Recipient Management LOCK-IN System. The ~~Department of Health and Human Services,~~ Division ~~of Medical Assistance, will~~ shall establish a lock-in system to control recipient overutilization of provider services. A lock-in system restricts an overutilizing recipient to the use of one physician and one pharmacy, of the recipient's choice, provided the recipient's physician is able to ~~can~~ refer the recipient to other physicians as medically necessary, as defined in 10A NCAC 25A .0201. ~~necessary.~~

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 108A-63; 108A-64; 108C; 42 C.F.R. Part 455; 42 CFR 455.23; 42 C.F.R. 447.15;*
Eff. May 1, 1984; ~~1984.~~
Readopted Eff. September 1, 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~~ 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.

10A NCAC 22F .0302 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0302 INVESTIGATION

(a) ~~Abusive practices~~ Fraud, waste, abuse, [~~overutilization,~~] error, or practices not conforming to state and federal Medicaid laws and regulations, [~~regulations or~~] clinical coverage policies, [~~policy~~] or the Medicaid State Plan shall be investigated according to the provisions of Rule .0202 of this Subchapter.

(b) A Provider Summary Report shall be prepared by the Division ~~investigative unit~~ furnishing the full investigative findings of fact, conclusions, and recommendations.

(c) The Division shall review the findings, conclusions, and recommendations and make a tentative decision for disposition of the case. ~~case~~ The Division shall seek full restitution of any improper provider payments as required by 10A NCAC 22F .0601. In addition, upon determination that program abuse has occurred and based on the factors set out in Rule .0602(b) of this Subchapter, the Division may also take one or more administrative actions pursuant to Rule .0602 of this Subchapter. [~~of~~] ~~from among the following administrative actions:~~

~~(1) [to recommend suspension or termination;] To place provider on probation with terms and conditions for continued participation in the program.~~

~~(2) [to place the provider on probation with terms and conditions for continued participation in the program including, placing the provider on prepayment claims review pursuant to G.S. 108C-7;] To recover in full any improper provider payments.~~

~~(3) [to] To negotiate a financial settlement with the [provider;] provider.~~

~~(4) [to] To impose remedial measures to include a monitoring program of the provider's Medicaid practice terminating with a "follow up" review to ensure corrective measures have been [introduced; or] introduced.~~

~~(5) [to] To issue a warning letter notifying the provider that he [or she] must not continue his [or her] aberrant practices or he [or she] will be subject to further division actions.~~

~~(6) To recommend suspension or termination.~~

(d) The tentative decision shall be subject to the review procedures described in Section .0400 of this Subchapter.

(e) If the investigative findings show that the provider is not licensed or certified as required by federal and State ~~state~~ law, then the provider shall not ~~cannot~~ participate in the North Carolina State Medical Assistance Program (Medicaid). The Division is required to verify provider licensure pursuant to 42 C.F.R. 455.412, [~~455.12;~~] which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/.

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 108A-63; 108C-5; 108C-7; 42 C.F.R. 455, Subpart A; 455.412;[~~455 C.F.R. 412;~~] ~~455.14; 42 C.F.R. 455.15;~~*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1988; May 1, 1984; ~~1984.~~

Readopted Eff. September 1, 2018.

10A NCAC 22F .0602 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0602 ADMINISTRATIVE ACTIONS ~~SANCTIONS AND REMEDIAL MEASURES~~

(a) The following types of administrative actions ~~sanctions~~ [~~or remedial measures~~] may be imposed in any particular order ~~imposed, singly or in combination,~~ by the Division ~~Medicaid Agency~~ in instances of program abuse by [~~providers,~~] providers: [~~which do not have to be imposed in any particular order:~~]

(1) warning ~~Warning~~ letters for ~~those~~ instances of abuse that can be ~~satisfactorily~~ settled by issuing a warning to cease the specific abuse. The letter shall ~~will~~ state that any further violations shall ~~will~~ result in administrative or legal action initiated by the Division; ~~Medicaid Agency.~~

(2) suspension ~~Suspension~~ of a provider from further participation in the Medicaid Program for a specified period of time, subject to appeal rights under G.S. 150B, Article 3, provided that ~~the appropriate~~ findings have been made by the Divison ~~and provided~~ that this action shall ~~does~~ not deprive recipients of access to reasonable service of adequate quality as set out in 42 C.F.R. 440.230, 440.260, and 455.23, which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/; ~~quality.~~

(3) termination ~~Termination~~ of a provider from further participation in the Medicaid Program, subject to appeal rights under G.S. 150B, Article 3, provided that ~~the appropriate~~ findings have been made by the Division ~~and provided~~ that this action shall ~~does~~ not deprive recipients of access to reasonable services of adequate quality as set out in 42 C.F.R. 440.230, 440.260, and 455.23, which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov; ~~quality.~~

(4) probation ~~Probation~~ whereby a provider's participation is ~~closely~~ monitored for a specified period of time not to exceed one year, subject to appeal rights under G.S. 150B, Article 3. ~~year.~~ At the termination of the probation period the Division ~~Medicaid Agency~~ shall ~~will~~ conduct a follow-up review of the provider's Medicaid practice to ensure compliance with all applicable laws, regulations, and conditions of participation in Medicaid; [~~Medicaid.~~] ~~the Medicaid rules. Notwithstanding his probation, a probationary provider's participation, like that of all providers, is terminable at will.~~

(5) negotiation of a financial settlement with the provider;

(6)~~(5)~~ ~~Remedial Measures to include:~~

~~(A)~~ placing the provider on prepayment review in accordance with G.S. 108C-7; ~~"flag" status whereby his claims are remanded for manual review;~~ or

(7)[~~(6)~~]~~(B)~~ establishing a monitoring program not to exceed one year whereby the provider shall ~~must~~ comply with pre-established conditions of participation to allow review and evaluation of the provider's Medicaid claims. ~~his Medicaid practice, i.e., quality of care.~~

(b) The following factors are illustrative of those to be considered in determining the kind and extent of administrative actions ~~sanctions~~ to be imposed:

(1) seriousness of the offense;

(2) extent of violations found;

(3) history of ~~or~~ prior violations;

(4) prior imposition of sanctions;

(5) ~~period~~ length of time provider practiced violations;

(6) provider willingness to obey program rules;

(7) recommendations by the investigative staff or Peer Review Committees; and

(8) effect on health care delivery in the area.

(c) When the Division has taken administrative action against a provider under Paragraphs (a)(2), (a)(3), or (a)(4) of this Rule, [~~a provider has been administratively sanctioned,~~] the Division shall notify the licensing board or other certifying group governing the sanctioned provider, ~~appropriate professional society, board of licensure, State Attorney General's Office,~~ federal and state agencies, and ~~appropriate county~~ departments of social services in the counties where beneficiaries served by the provider reside of the findings made and the sanctions imposed.

History Note: *Authority G.S. 108A-25(b);108A-54; 108A-54.1B; 108C-5; 108C-7; 42 C.F.R. 440.230; 42 C.F.R. 440.260; 42 C.F.R. Part 431; 42 C.F.R. Part 455;42 C.F.R. 455.23; 42 C.F.R. 455.101; 42 C.F.R. 1002.3*
Eff. May 1, 1984;
Amended Eff. December 1, 1995; May 1, 1990; ~~1990.~~
Readopted Eff. September 1, 2018.

10A NCAC 22F .0603 is proposed for readoption without substantive change as follows:

10A NCAC 22F .0603 PROVIDER LOCK-OUT

(a) The Division may suspend the provider, based on the factors set out in Rule .0602(b) of this Subchapter, ~~restrict the~~ [~~provider through suspension~~] ~~provider, through suspension or otherwise,~~ from participating in the Medicaid program, provided ~~that~~: that the Division meets the requirements of 42 C.F.R. 431.54(f), which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/.

~~(1) Before imposing any restrictions, the Division [shall] will give the provider notice and opportunity for [review.] review in accordance with procedures established by the Division.~~

~~(2) The Division [shall demonstrate a relevant and factual basis for imposing the restriction.] shows, before so restricting a provider, that in a significant number of proportion of cases, the provider has:~~

~~(A) provided care, services, and items at a frequency or amount not medically necessary, as determined in accordance with utilization guidelines established by the Division; or~~

~~(B) provided care, service, and items of a quality that does not meet professionally recognized standards of health care.~~

~~(3) The Division [shall] will assure that recipients do not lose reasonable access to services of adequate quality [quality, as set out in 42 C.F.R. 440.230, 440.260, and 431.54, which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/,] as a result of such restrictions.~~

~~(4) The Division [shall] will give general notice to the public of the restriction, its basis, and its duration.~~

(b) Suspension or termination from participation of any provider shall preclude the ~~such~~ provider from submitting claims for payment to the Division. ~~state agency.~~ No claims may be submitted by or through any clinic, group, corporation, or other association for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Medicaid program, except for those services or supplies provided prior to the suspension or termination effective date.

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 42 C.F.R. 440.230; 42 C.F.R. 440.260; 42 C.F.R. Part 431; 42 C.F.R.431.54; 42 C.F.R. Part 455;*
Eff. May 1, 1984;
Amended Eff. December 1, 1995; ~~1995.~~
Readopted Eff. September 1, 2018.

10A NCAC 22F .0604 proposed for readoption without substantive changes as published in 32:13 NCR 1258–1268 is repealed through readoption as follows:

10A NCAC 22F .0604 SUSPENDING~~WITHHOLDING~~ OF MEDICAID PAYMENTS

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 108C-5; 150B-21.6; 42 C.F.R. Part 431; 42 C.F.R. ~~Part~~ 455.23; ~~455;~~*
Eff. May 1, 1984;
Amended Eff. December 1, 1995; ~~1995.~~
Repealed Eff. September 1, 2018.

10A NCAC 22J .0105 proposed for readoption without substantive changes as published in 32:13 NCR 1258–1268 is repealed through readoption as follows:

10A NCAC 22J .0105 PAYMENT STATUS

History Note: *Authority G.S. 108A-25(b); 108A-54; ~~150B-11;~~ 42 U.S.C. 1396b(d)(2);*
Eff. January 1, 1988; ~~1988.~~
Repealed 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 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

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1711 New Hope Church Rd
Raleigh, NC 27609-6285

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

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0104

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:

Is the intent of (a) that if a provider asks, then the Division will conduct an on-site educational visit? If so, please say "Upon the request of a provider, the Division shall conduct an on-site…"

In (d), is the process for "prior approval" set forth elsewhere in rule, statute, cfr, or the Plan?

In (e), line 20, please delete "shall be binding on the Division and the providers:" as unnecessary.

For purposes of consistency with the remainder with the other sub-paragraphs, please change "constitutes" to "shall constitute" in (e)(1).

In (e)(6), are the factors that will go into deciding whether the Division will suspend or terminate a provider set forth elsewhere?

In (g), what is a lock-in system? Is this already in place? Is this specific to each individual provider or is it a provider wide system? I'm a bit confused by "the Division shall establish…" as this language appears to have been in this Rule since 1984 – is it still accurate?

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 .0104 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0104 PREVENTION

(a) Provider Education. The Division may, ~~may at its discretion, or shall~~ upon the request of a provider, conduct on-site educational visits to assist a provider in complying with requirements of the Medicaid Program.

(b) Provider Manuals. The Division shall ~~will~~ prepare and make available ~~furnish each provider with~~ a provider manual containing at least the following information:

(1) amount, duration, and scope of assistance;

(2) participation standards;

(3) penalties;

(4) reimbursement rules; and

(5) claims filing instructions.

(c) Prepayment Claims Review. The Division shall ~~will~~ check eligibility, duplicate payments, third party liability, and unauthorized or uncovered services by means of prepayment review, computer edits and audits, and investigation. ~~other appropriate methods of review.~~

(d) Prior Approval. The Division shall require prior approval for certain specified covered services as set forth in the Medicaid State Plan.

(e) Claim Forms. The following terms and conditions shall apply to the submission of claims [~~Claim~~] forms and [~~shall contain~~] ~~The Division's provider claim forms shall include the following requirements~~ [~~that~~] ~~for provider participation and payment. These requirements~~ shall be binding on ~~upon~~ the Division and the providers:

(1) [~~medicaid~~]Medicaid payment constitutes payment in full;~~full.~~

(2) charges~~Charges~~ to Medicaid recipients for the same items and services shall not be higher than for private paying patients;~~patients.~~

(3) the~~The~~ provider shall keep all records as necessary to support the services claimed for reimbursement;~~reimbursement.~~

(4) the~~The~~ provider shall ~~fully~~ disclose the contents of his Medicaid financial and medical records to the Division and its agents;~~agents.~~

(5) [~~medicaid~~]Medicaid reimbursement shall only be made for medically necessary care and services as defined in 10A NCAC 25A .0201; and ~~services.~~

(6) the~~The~~ Division may suspend or terminate a provider for violations of Medicaid laws, federal regulations, the rules of this Subchapter, the provider administrative participation agreement, the Medicaid State Plan, and Medicaid Clinical Coverage policies. ~~policies, or guidelines.~~

(f) ~~Pharmacy and Institutional~~ Provider Administrative Participation Agreements. All ~~institutional and pharmacy~~ providers shall ~~be required to~~ execute a written participation agreement as a condition for participating in the N.C. State Medicaid ~~Medical Assistance~~ Program.

(g) The Recipient Management LOCK-IN System. The ~~Department of Health and Human Services,~~ Division ~~of Medical Assistance, will~~ shall establish a lock-in system to control recipient overutilization of provider services. A

lock-in system restricts an overutilizing recipient to the use of one physician and one pharmacy, of the recipient's choice, provided the recipient's physician is able to ~~can~~ refer the recipient to other physicians as medically necessary, as defined in 10A NCAC 25A .0201. ~~necessary.~~

History Note: *Authority G.S. 108A-25(b); 108A-63; 108A-64; 42 C.F.R. Part 455; 42 CFR 455.23;*
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;
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 .0302

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:

What are clinical coverage policies? Are these agreements entered into with the providers?

What is the "investigative unit"? Is this not the Division?

In looking at Rule .0202 of this Subchapter, I assume that this Rule will come into play only if "the case is found to be one of program abuse subject to administrative action"?

In (c), would it be appropriate to add something like "upon a determination by the Division based upon their investigation that program abuse has occurred, the Division shall seek restitution in accordance with 10A NCAC 22F .0601 and may also take one of more of the following administrative actions:" Please see my notes for 22F .0602.

In (c), how will the Division determine whether to take additional action? Are these set forth elsewhere in rule or statute?

In (c)(1) – who has final decision making power to suspend or terminate? To whom is the recommendation being made? It appears to me that the Department has the authority to take this action so is "recommendation" accurate? Please clarify.

In (e), please capitalize "state"

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 .0302 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0302 INVESTIGATION

(a) ~~Abusive practices~~ Fraud, waste, abuse, [~~overutilization,~~] error, or practices not conforming to state and federal Medicaid laws and regulations, [~~regulations or~~] clinical coverage policies, [~~policy~~] or the Medicaid State Plan shall be investigated according to the provisions of Rule .0202 of this Subchapter.

(b) A Provider Summary Report shall be prepared by the investigative unit furnishing the full investigative findings of fact, conclusions, and recommendations.

(c) The Division shall review the findings, conclusions, and recommendations and make a tentative decision for disposition of the case. ~~case~~ The Division shall seek full restitution of any improper provider payments as required by 10A NCAC 22F .0601. In addition, the Division may also take one or more of ~~from among~~ the following administrative actions:

(1) to recommend suspension or termination; ~~To place provider on probation with terms and conditions for continued participation in the program.~~

(2) to place the provider on probation with terms and conditions for continued participation in the program; [~~program including, placing~~]

(3) to place the provider on prepayment claims review pursuant to G.S. 108C-7; ~~To recover in full any improper provider payments.~~

~~(3)~~(4) to ~~To~~ negotiate a financial settlement with the provider; ~~provider.~~

~~(4)~~(5) to ~~To~~ impose remedial measures to include a monitoring program of the provider's Medicaid practice terminating with a "follow-up" review to ensure corrective measures have been introduced; or ~~introduced.~~

~~(5)~~(6) to ~~To~~ issue a warning letter notifying the provider that he or she must not continue his or her ~~aberrant~~ practices not conforming to state and federal Medicaid laws and regulations, clinical coverage policies, or the Medicaid State Plan or he or she will be subject to further division actions.

~~(6) To recommend suspension or termination.~~

(d) The tentative decision shall be subject to the review procedures described in Section .0400 of this Subchapter.

(e) If the investigative findings show that the provider is not licensed or certified as required by federal and state law, then the provider shall not ~~cannot~~ participate in the North Carolina State Medical Assistance Program (Medicaid). The Division is required to verify provider licensure pursuant to 42 C.F.R. 455.12, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/.

History Note: *Authority G.S. 108A-25(b); 108A-63; 108C-7; 42 C.F.R. 455, Subpart A; 455 C.F.R. 412; ~~455.14; 42 C.F.R. 455.15;~~*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1988; May 1, 1984; ~~1984.~~

Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0602

DEADLINE FOR RECEIPT: Friday, June 8, 2018

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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:

What are these? (b) references "administrative sanctions", (a) references "sanctions or remedial measures." Please be consistent. (Also, keep in mind that .0302 references "administrative actions."

I'm a bit confused as to what the difference is between the actions contained in 10A NCAC 22F .0302(c) and this Rule. Is .0302 applicable for provider abuse and .0602 is applicable to program abuse by providers? I don't read them as being different (though if they are the same, please make them consistent)? Please note that .0301 current just defines "abuse" without the title, which just adds to the confusion here.

In (a), please consider deleting "which do not have to be imposed in any particular order" or other move it to the end.

Please change the period to a semi-colon at the end of (a)(4) and add an "and" or an "or", whichever is applicable. Please also make the "R" in "Remedial" lower case in (a)(5).

In (b)(7), what is a peer review committee? It's possible that this is already set forth elsewhere in your rules, but all I've seen is the investigation by the division.

Please make page 2, line 6 beginning "when a provider…" its own Paragraph. Also, please delete or define "appropriate" in "appropriate county department"

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 .0602 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0602 ADMINISTRATIVE SANCTIONS AND REMEDIAL MEASURES

(a) The following types of sanctions or remedial measures may be imposed ~~imposed, singly or in combination,~~ by the Division ~~Medicaid Agency~~ in instances of program abuse by providers, ~~providers:~~which do not have to be imposed in any particular order:

(1) warning ~~Warning~~ letters for ~~those~~ instances of abuse that can be ~~satisfactorily~~ settled by issuing a warning to cease the specific abuse. The letter shall ~~will~~ state that any further violations shall ~~will~~ result in administrative or legal action initiated by the Division; ~~Medicaid Agency.~~

(2) suspension ~~Suspension~~ of a provider from further participation in the Medicaid Program for a specified period of time, provided that ~~the appropriate~~ findings have been made by the Divison ~~and provided~~ that this action shall ~~does~~ not deprive recipients of access to reasonable service of adequate quality as set out in 42 C.F.R. 440.230, 440.260, and 455.23, which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/; ~~quality.~~

(3) termination ~~Termination~~ of a provider from further participation in the Medicaid Program, provided that ~~the appropriate~~ findings have been made by the Division ~~and provided~~ that this action shall ~~does~~ not deprive recipients of access to reasonable services of adequate quality as set out in 42 C.F.R. 440.230, 440.260, and 455.23, which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov; ~~quality.~~

(4) probation ~~Probation~~ whereby a provider's participation is ~~closely~~ monitored for a specified period of time not to exceed one year. At the termination of the probation period the Division ~~Medicaid Agency~~ shall ~~will~~ conduct a follow-up review of the provider's Medicaid practice to ensure compliance with all applicable laws, regulations, and conditions of participation in Medicaid. ~~the Medicaid rules. Notwithstanding his probation, a probationary provider's participation, like that of all providers, is terminable at will.~~

(5) Remedial Measures may include, but are not limited to: ~~to include:~~

(A) placing the provider on prepayment review in accordance with G.S. 108C-7; ~~"flag" status whereby his claims are remanded for manual review;~~ or

[~~(6)~~] (B) establishing a monitoring program not to exceed one year whereby the provider shall ~~must~~ comply with pre-established conditions of participation to allow review and evaluation of the provider's Medicaid claims. ~~his Medicaid practice, i.e., quality of care.~~

(b) The following factors are illustrative of those to be considered in determining the kind and extent of administrative sanctions to be imposed:

(1) seriousness of the offense;

(2) extent of violations found;

(3) history of ~~or~~ prior violations;

(4) prior imposition of sanctions;

(5) ~~period~~ length of time provider practiced violations;

(6) provider willingness to obey program rules;

(7) recommendations by the investigative staff or Peer Review Committees; and

(8) effect on health care delivery in the area.

When a provider has been administratively sanctioned, the Division shall notify the licensing board or other certifying group governing the sanctioned provider, ~~appropriate professional society, board of licensure, State Attorney General's Office,~~ federal and state agencies, and appropriate county departments of social services of the findings made and the sanctions imposed.

History Note: *Authority G.S. 108A-25(b); 108C-5; 108C-7; 42 C.F.R. 440.230; 42 C.F.R. 440.260; 42 C.F.R. Part 431; 42 C.F.R. Part 455; 42 C.F.R. 455.23;*
Eff. May 1, 1984;
Amended Eff. December 1, 1995; May 1, 1990; ~~1990.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0603

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:

By "the division may restrict the provider through suspension" do you mean "the Division may suspend the provider"?

How will the decision be made whether to suspend the provider? Based upon those factors contained in .0602(b)?

Please end (a)(1), (2), and (a)(3) with semi-colons, and add an "and" at the end of (a)(3). Please also begin (a)(1) through (a)(4) with lower case letters for purposes of consistency.

In (a)(2), what is meant by "relevant and factual"? Please delete or define.

In (a)(4), how does the Division give notice to the public? Is this set forth elsewhere in rule, statute, or CFR?

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 .0603 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0603 PROVIDER LOCK-OUT

(a) The Division may restrict the provider through suspension ~~provider, through suspension or otherwise,~~ from participating in the Medicaid program, provided that:

(1) Before imposing any restrictions, the Division shall ~~will~~ give the provider notice and opportunity for review. ~~review in accordance with procedures established by the Division.~~

(2) The Division shall demonstrate a relevant and factual basis for imposing the restriction. ~~shows, before so restricting a provider, that in a significant number of proportion of cases, the provider has:~~

~~(A) provided care, services, and items at a frequency or amount not medically necessary, as determined in accordance with utilization guidelines established by the Division; or~~

~~(B) provided care, service, and items of a quality that does not meet professionally recognized standards of health care.~~

(3) The Division shall ~~will~~ assure that recipients do not lose reasonable access to services of adequate ~~quality~~ quality, as set out in 42 C.F.R. 440.230, 440.260, and 431.54, which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/, as a result of such restrictions.

(4) The Division shall ~~will~~ give general notice to the public of the restriction, its basis, and its duration.

(b) Suspension or termination from participation of any provider shall preclude the ~~such~~ provider from submitting claims for payment to the Division. ~~state agency.~~ No claims may be submitted by or through any clinic, group, corporation, or other association for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Medicaid program, except for those services or supplies provided prior to the suspension or termination effective date.

History Note: *Authority G.S. 108A-25(b); 42 C.F.R. 440.230; 42 C.F.R. 440.260; 42 C.F.R. Part 431; 42 C.F.R.431.54; 42 C.F.R. Part 455;*
Eff. May 1, 1984;
Amended Eff. December 1, 1995; ~~1995.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0604

DEADLINE FOR RECEIPT: Friday, June 8, 2018

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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:

> *Is (b) necessary? GS 108C-5 and 42 CFR 455.23 appear to set forth exactly when this may occur and how. If (b) is necessary, what is your authority to suspend payment to "implement the penalty provision of the Patient's Bill of Rights"? I see that you have the authority to suspend payment for fraud under 42 CFR 455.23 and for overpayment pursuant to 108C-5, but I'm not sure where the penalty provision comes in under the cited authority. Also, I'm not exactly sure what "penalty provision" is referring to.*
>
> *Please remove the comma after "overpayments"*

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 .0604 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0604 SUSPENDING~~WITHHOLDING~~ OF MEDICAID PAYMENTS

(a) The Division ~~Medicaid Agency~~ shall suspend ~~withhold~~ Medicaid payments in accordance with the provisions of G.S. 108C-5 and 42 CFR 455.23, ~~455.23~~ which is ~~hereby~~ incorporated by reference with ~~including~~ subsequent changes or amendments, and available free of charge at https://www.ecfr.gov/. ~~amendments and editions. A copy of 42 CFR 455.23 is available for inspection and may be obtained from the Division of Medical Assistance at a cost of twenty cents ($.20) a page.~~

(b) The Division ~~Medicaid Agency~~ shall suspend ~~withhold~~ Medicaid payments in whole or in part to ensure recovery of overpayments, or to implement the penalty provision of the Patient's Bill of Rights described at 10A NCAC 13B .3302. ~~Rights.~~

History Note: *Authority G.S. 108A-25(b); 108C-5; 150B-21.6; 42 C.F.R. Part 431; 42 C.F.R. ~~Part~~ 455.23; ~~455;~~*
Eff. May 1, 1984;
Amended Eff. December 1, 1995; ~~1995.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22J .0105

DEADLINE FOR RECEIPT: Friday, June 8, 2018

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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:

> *How will the Division recover the overpayment? I assume that this is set forth elsewhere in rule, statute, or CFR? Is there a cross-reference available?*

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 22J .0105 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22J .0105 PAYMENT STATUS

Once a final overpayment or final erroneous payment is determined by the Division ~~DMA~~ to exist, the Division shall act ~~action will be taken immediately~~ to recover such overpayment or erroneous payment from the provider. ~~payment.~~ If the provider's appeal is successful, repayment shall ~~will~~ be made to the provider.

History Note: *Authority G.S. 108A-25(b); 108A-54; ~~150B-11;~~ 42 U.S.C. 1396b(d)(2);*
Eff. January 1, 1988; ~~1988.~~
Readopted Eff. July 1, 2018.

10A NCAC 22J .0106 is readopted 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 but will charge the patient for all services provided.

(b) Acceptance of a patient as a Medicaid patient by a provider 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 is provided the provider has informed the patient that the patient may be billed for a service that is not one covered by Medicaid regardless of the type of provider or is beyond the limits 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 are received but has failed to supply a Medicare number as proof of coverage; or

(4) the patient is 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 provided to a Medicaid patient, the provider shall not bill the Medicaid patient for Medicaid services 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 provided, except that a provider shall ~~may~~ not deny services 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 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 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-54.2; ~~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. July 1, 2018.