10A NCAC 21A .0301 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

SECTION .0300 - APPEALS

10A NCAC 21A .0301 NOTICE

In cases involving termination or modification of assistance, no action shall become effective until ten business ~~work~~ days after the notice is mailed, ~~mailed or delivered,~~ except that it may be effective immediately upon the mailing of notice when:

(1) modification ~~Modification~~ results in an increase in benefits ~~is beneficial~~ to the applicant or beneficiary; ~~client;~~ or

(2) permitted pursuant to ~~Federal regulations at~~ 42 C.F.R. 431.213, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/. ~~431.213 are adopted by reference pursuant to 150B-14(c).~~

History Note: *Authority G.S. 108A-54; 108A-54.1B; ~~108A-79~~ 108A-79(b); ~~150B-14(c);~~ 42 C.F.R. 431.211; 42 C.F.R. 431.213;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990; ~~1990.~~
Readopted Eff. July 1, 2018.

10A NCAC 21A .0302 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 21A .0302 GOOD CAUSE FOR DELAYED HEARINGS

(a) A local appeal hearing under G.S. 108A-79 shall be delayed as provided in G.S. 108-79(e) for good cause. ~~cause as provided in G.S. 108A-79(e).~~

(b) A State ~~state~~ appeal hearing under G.S. 108A-79 may be delayed [~~for as much as 30 calendar days~~] when there is good cause. The postponement shall ~~may~~ not exceed 30 calendar days.

(c) For purposes of this Rule, good ~~Good~~ cause exists when:

(1) there~~There~~ is a death in the appellant's family;

(2) the~~The~~ appellant or someone in his or her family is ill;

(3) the~~The~~ appellant is unable to obtain representation;

(4) the~~The~~ appellant's representative has a conflict with the scheduled date;

(5) the~~The~~ appellant receives a notice of action proposing a reduction or termination of assistance after the ten business ~~work~~ day notice expires;

(6) the~~The~~ appellant is unable to obtain transportation; or

(7) the~~The~~ hearing officer determines that the hearing should be delayed for some other reason in the interests of justice or to promote judicial economy. ~~other circumstances satisfactory to the hearing officer.~~

History Note: *Authority G.S. 108A-54; 108A-54.1B; 108A-79;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990; ~~1990.~~
Readopted Eff. July 1, 2018.

10A NCAC 21A .0303 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 21A .0303 APPEAL DECISION

(a) The hearing officer shall make a tentative decision on the appeal that ~~which~~ shall be served upon the county department, ~~department and~~ the ~~appellant~~ appellant, and representatives by mail. Decisions reversing ~~proposing to reverse~~ the county department's action shall be sent by certified mail to the county department. ~~department while decisions~~ Decisions affirming the county department's actions shall ~~will~~ be sent by certified mail to the appellant. Decisions shall be sent by regular mail to representatives. The tentative decision shall contain a notification of the right to present oral and written argument for and against the decision as set out in this Rule.

(b) The county and the appellant may present oral and written argument, for and against the decision ~~decision.~~ by contacting the Chief Hearing Officer. ~~Written argument may be submitted to or contact made with the Chief Hearing officer to request a hearing for oral argument.~~

(c) If a written argument, a request for a time extension to submit a written argument, or a request for oral argument is not received by the Chief Hearing Officer ~~is not contacted~~ within 10 calendar days of the date the notice of the tentative decision is signed, the tentative decision shall become final.

(d) If a request for a time extension to submit [~~an~~] a written argument or a request for an oral argument is received by the Chief Hearing Officer [~~officer~~] within 10 calendar days of the date the notice of the tentative decision is signed, an extension [~~may~~] shall be granted and a letter shall be mailed stating the date the written argument is due or the date and time the oral argument shall be heard. [~~for good cause or in the interests of justice.~~]

(e)~~(d)~~ If the party that requested oral argument fails to appear ~~at the hearing~~ for the scheduled oral argument, the tentative decision shall become ~~becomes~~ final.

(f)~~(e)~~ If ~~oral~~ [~~or~~] ~~and~~ ~~written~~ arguments are ~~presented,~~ presented within the timeframes established in Paragraphs (c) and (d) of this Rule, then all such arguments shall be considered and a final decision shall be rendered.

(g)~~(f)~~ The final decision shall be served upon ~~mailed to~~ the appellant and ~~any~~ the county department by certified mail. Decisions shall be sent by regular mail to representatives.

(h)~~(g)~~ A decision upholding the appellant shall be put into effect within two weeks after the county department's receipt of the final decision ~~decision.~~ by certified mail.

(i)~~(h)~~ As provided for in 42 C.F.R. 431.245 ~~431.245,~~ and G.S. 108A-79(k), the decision shall contain the appellant's right to ~~request a State agency hearing and~~ seek judicial review. ~~review to the extent that either is available to him~~.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 108A-79; 42 C.F.R. 431.244; 42 C.F.R. 431.245; 42 C.F.R. 431.246;*
Eff. September 1, 1984;
Amended Eff. September 1, 1992; ~~1992.~~
Readopted Eff. July 1, 2018.

10A NCAC 21B .0204 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 21B .0204 EFFECTIVE DATE OF ASSISTANCE

(a) The first month of Medicaid coverage shall be:

(1) theThe month of application, or for SSI recipients, the month of application for SSI; or

(2) asAs much as three months prior to the month of application when the client received medical services covered by the program and was eligible during the month or months of medical need; or

(3) ifIf the client applies prior to meeting a non-financial requirement, no earlier than the calendar month in which all non-financial requirements are met.

(b) Assistance shall be authorized beginning on the first day of the month except when:

(1) theThe client's income exceeds the income level and he or she must spenddown the excess income for medical care. The assistance shall be authorized on the day his or her incurred medical care costs equal the amount of the excess income; or income.

(2) For groups identified in Rule .0311, Sub-item (3)(a) of this Subchapter, the client shall be authorized on the day the reserves are reduced, or incurred medical care costs equal the amount of the excess income, whichever occurs later. otherwise stated in the Medicaid State Plan.

(c) Medicaid coverage shall end on the last day of the last month of eligibility except for those individuals eligible for emergency conditions only as described in 10A NCAC 23E .0102. The last month of eligibility shall be the month in which the notice of termination period described in 10A NCAC 21A .0301 expires. be:

(1) The month in which timely notice of termination expires; or

(2) The month in which adequate notice of termination expires.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 42 C.F.R. 435.915; 435.914; 42 C.F.R. 435.919; Alexander v. Bruton Consent Order dismissed Effective February 1, 2002;*
Eff. September 1, 1984;
Amended Eff. January 1, 1995; October 1, 1991; August 1, 1990;
Temporary Amendment Eff. March 1, 2003;
Amended Eff. August 1, 2004; 2004.
Readopted Eff. July 1, 2018.

10A NCAC 22B .0103 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22B .0103 INSTITUTIONAL STANDARDS

Institutions shall ~~must~~ meet standards prescribed for participation in Titles XVIII, XIX, and XXI of the Social Security Act, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at http://uscode.house.gov/. ~~and XIX.~~ These standards are set forth in ~~specified by~~ North Carolina ~~state~~ licensing law and ~~by~~ federal ~~statutes and~~ regulations, and are kept on file in the Department of Health and Human Services, Division of Health Services Regulation ~~state agency~~ and available on request.

History Note: *Authority G.S. 108A-25(b); 108A-54; 131-E; 42 C.F.R. 440.10; 42 C.F.R. Part 442; 42 C.F.R. 457.990; ~~442, Subparts (D)(E);~~*
Eff. February 1, 1976;
Readopted Eff. October 31, 1977; ~~1977.~~
Readopted Eff. July 1, 2018.

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

10A NCAC 22B .0104 TIME LIMITATION

(a) To receive payment, claims shall ~~must~~ be filed either:

(1) within ~~Within~~ 365 days of the date of service for services other than inpatient hospital, home health, ~~health~~ or nursing home services; ~~or~~

(2) within ~~Within~~ 365 days of the date of discharge for inpatient hospital services and the last date of service in the month for home health and nursing home services, ~~services~~ not to exceed the limitations as specified in 42 C.F.R. 447.45, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/; ~~447.45;~~ or

(3) within ~~Within~~ 180 days of the Medicare or other third party payment or ~~payment, or within 180 days of~~ final denial, when the date of the third party payment or denial exceeds the filing limits in Subparagraphs (1) or (2) of this Paragraph, ~~Rule,~~ if it is [~~may~~] ~~can~~ ~~be~~ shown that:

(A) a ~~A~~ claim was filed with a prospective third-party payor within the filing limits in Subparagraph (1) or (2) of this Paragraph; ~~Rule; and~~

(B) [~~there~~] ~~There~~ ~~was a possibility of receiving~~ payment from the third party payor with whom the claim was filed is pending; ~~filed;~~ and

(C) documented [~~good faith~~] ~~Bona fide and timely~~ efforts were made ~~pursued~~ to achieve either payment or final denial of the third-party claim.

(b) Providers shall ~~must~~ file requests for payment adjustments or requests for reconsideration of a denied claim no later than 18 months after the date of payment or denial of a claim.

(c) The time limitation specified in Paragraph (a) of this Rule shall ~~may~~ be waived by the Division ~~of Medical Assistance~~ when there is a correction of an administrative error in determining eligibility by the county or ~~eligibility,~~ application of court order or hearing decision that grants eligibility with less than 60 days for providers to submit claims for eligible dates of service, provided the claim is received for processing within 180 days after the date the county department of social services approves the eligibility.

(d) In cases where claims or adjustments were not filed within the time limitations specified in Paragraphs (a) and (b) of this Rule, and the provider shows good cause for the failure to do so, ~~so was beyond his control, he~~ the provider may request a reconsideration review by the Director of the Division. ~~Division of Medical Assistance.~~ "Good cause" is an action uncontrollable by the provider. The Director of the Division ~~Medical Assistance~~ shall be ~~is~~ the final authority for reconsideration reviews. If the provider wishes to contest this decision, he may do so by filing a petition for a contested case hearing in conformance with G.S. 150B-23.

History Note: *Authority G.S. 108A-25(b); 108A-54; 42 C.F.R. 447.45;*
Eff. February 1, 1976;
Amended Eff. October 1, 1977;

Readopted Eff. October 31, 1977;

Amended Eff. June 1, 1993; June 1, 1988; November 1, 1986; July 1, 1985; ~~1985.~~

Readopted Eff. July 1, 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. 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) Claim Forms. The following terms and conditions shall apply to the submission of claims forms: [~~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.~~

(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.

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

10A NCAC 22F .0105 DETECTION

History Note: *Authority G.S. 108A-25(b); 108A-63; 108A-64; 42 C.F.R. Part 455; 42 C.F.R. 455.12–23;*
Eff. May 1, 1984; ~~1984.~~
Readopted Eff. July 1, 2018.

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

10A NCAC 22F .0106 CONFIDENTIALITY

All investigations by the ~~North Carolina~~ Division ~~of Medical Assistance~~ concerning allegations of provider fraud, abuse, over-utilization, or inadequate quality of care shall be confidential, and the information contained in the files of such investigations shall be confidential, except as permitted by State or Federal law or regulation.

History Note: *Authority G.S. 108A-25(b); 108A-63; 108A-64; 132-1.3; 42 C.F.R. Part 455; 42 C.F.R. 455.21;*
Eff. May 1, 1984;
Amended Eff. May 1, 1990; ~~1990.~~
Readopted Eff. July 1, 2018.

10A NCAC 22F .0201 proposed for readoption without substantive changes as published in 32:13 NCR 1258–1268 is repealed through readoption as follows:

SECTION .0200 - PROVIDER FRAUD AND PHYSICAL ABUSE OF RECIPIENTS

10A NCAC 22F .0201 DEFINITION OF PROVIDER FRAUD

History Note: *Authority G.S. 108A-25(b); 108A-63; ~~143B-10;~~ 150B-21.6; 42 U.S.C. 1396(b) et seq.; 42 C.F.R. Part 455;*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1990; May 1, 1984; ~~1984~~.
Readopted Eff. July 1, 2018.

10A NCAC 22F .0202 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0202 INVESTIGATION

~~(a) The Division will publish methods and procedures for the control of provider fraud, abuse, error, and overutilization.~~

(a)~~(b)~~ The Division ~~There~~ shall ~~be~~ conduct a preliminary investigation of all complaints received or allegations of fraud, waste, abuse, [~~overutilization,~~] error, or practices not conforming to state and federal Medicaid laws and regulations, clinical coverage policies, or the Medicaid State Plan [~~regulations or policy~~] ~~aberrant practices detected,~~ until it is determined:

(1) whether there are sufficient findings to warrant a full investigation, as set out in Paragraph (b) of this Rule; ~~investigation;~~

(2) whether there is sufficient evidence to warrant referring the case for civil fraud investigation, [~~and~~] ~~and/or~~ criminal fraud investigation, or both; ~~action;~~ or

(3) whether there is insufficient evidence to support the allegation(s) and the case may be closed.

(b)~~(c)~~ There shall be a full investigation if the preliminary findings support a credible allegation ~~the conclusion~~ of possible fraud until:

~~(1) the case is referred to the appropriate law enforcement agency;~~

(1)~~(2)~~ the case is found to be one of program abuse subject to administrative action, pursuant to Rule .0602 of this Subchapter; ~~action;~~

(2)~~(3)~~ the case is closed for insufficient evidence of fraud or abuse; or

(3)~~(4)~~ the provider is found not to have abused or defrauded the program.

History Note: *Authority G.S. 108A-25(b); 108A-63; 42 U.S.C. 1396(b) et seq.; 42 C.F.R. Part 455, Subpart A; ~~455;~~*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1984; ~~1984.~~
Readopted Eff. July 1, 2018.

10A NCAC 22F .0203 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0203 REFERRAL TO LAW ENFORCEMENT AGENCY

The Division shall refer credible allegations of ~~all cases of reasonably suspected~~ provider fraud, 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/, ~~fraud~~ or suspected physical abuse of recipients to the State Medicaid Fraud Control Unit or other law enforcement agency. ~~Unit.~~

History Note: *Authority G.S. 108A-25(b); 108A-63; P.L. 95-142; 42 C.F.R. 455.14; 42 C.F.R. 455.15; 42 C.F.R. 455.2;*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1984; ~~1984.~~
Readopted Eff. July 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 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.

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 of ~~from among~~ the following administrative actions:

(1) to suspend or terminate the provider; [~~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 ~~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-63; 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. July 1, 2018.

10A NCAC 22F .0402 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0402 RECONSIDERATION REVIEW FOR PROGRAM ABUSE

(a) The Division shall notify the provider in writing by certified mail of the tentative decision made pursuant to Rule .0302 of this subchapter and the opportunity for a reconsideration of the tentative decision. ~~Upon notification of a tentative decision the provider will be offered, in writing, by certified mail, the opportunity for a reconsideration of the tentative decision and the reasons therefor.~~

(b) The provider shall ~~will~~ be instructed to submit to the Division in writing a ~~his~~ request for a Reconsideration Review within 30 business ~~fifteen working~~ days from the date of receipt of the notice. Failure to request a Reconsideration Review in the specified time shall result in the implementation of the tentative decision as the [~~Department's~~] Division's final decision.

(c) ~~If requested, the~~ The Notice of Reconsideration Review shall be sent to the provider ~~scheduled~~ within 30 business ~~twenty calendar~~ days from receipt of the request. The provider shall ~~will~~ be notified in writing to appear at a specified day, time, ~~time~~ and place. The provider may be accompanied by legal counsel if the provider ~~he~~ so desires.

(d) The provider shall provide a written statement to the Hearing Unit prior to the Reconsideration Review identifying any claims that the provider wishes to dispute and setting forth the provider's specific reasons for disputing the determination on those claims.

(e)~~(d)~~ The purpose of the Reconsideration Review includes:

(1) clarification~~Clarification,~~ formulation, and simplification of issues;

(2) exchange~~Exchange~~ and full disclosure of information and materials;

(3) review~~Review~~ of the investigative findings;

(4) resolution~~Resolution~~ of matters in controversy;

(5) consideration~~Consideration~~ of mitigating and extenuating circumstances;

(6) reconsideration~~Reconsideration~~ of the administrative measures to be imposed; and

(7) reconsideration~~Reconsideration~~ of the restitution of overpayments.

(f)~~(e)~~ The Reconsideration Review decision shall ~~will~~ be sent to the provider, ~~provider~~ in writing by certified mail, ~~mail~~ within 30 business ~~five working~~ days following the date the review record is closed. The review record is closed when all arguments and documents for review have been received by the Hearing Unit. ~~of review. It will state the schedule for implementing the administrative measures and/or recoupment plan, if applicable, and it will~~ The decision shall state that ~~if the Reconsideration Review decision is not acceptable to the provider,~~ the provider ~~he~~ may request a contested case hearing in accordance with G.S. 150B, Article 3 and 26 NCAC 03 .0103. ~~the provisions found at 10A NCAC 01.~~ Pursuant to G.S. 150B-23(f), the provider shall have 60 days from receipt of the Reconsideration Review decision to request a contested case hearing in the Office of Administrative Hearings. ~~hearing.~~ Unless the request is received within the time provided, the Reconsideration Review decision shall become the Division's final decision and no further appeal shall be permitted. ~~decision. In processing the contested case request, the Director of the Division of Medical Assistance shall serve as the secretary's designee and shall be responsible for making the final agency decision.~~

History Note: *Authority G.S. 108A-25(b); 108A-54; 150B, Article 3; S.L. 2011-375, s. 2; ~~150B-22;~~ 42 C.F.R. Part 455.512; ~~455;~~*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
ARRC Objection October 22, 1987;
Amended Eff. November 1, 1988; March 1, 1988; May 1, 1984; ~~1984.~~
Readopted Eff. July 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, 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; [~~Medicaid.~~] ~~the Medicaid rules. Notwithstanding his probation, a probationary provider's participation, like that of all providers, is terminable at will.~~

(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

~~(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); 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.

10A NCAC 22F .0603 is readopted with changes as published in 32:13 NCR 1258–1268 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:

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

(2) the ~~The~~ Division shall demonstrate a [~~relevant and factual~~] basis for imposing the restriction; [~~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 ~~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; and ~~restrictions.~~

(4) The Division shall ~~will~~ give general notice to the public on its website 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.

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. ~~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.

10A NCAC 22F .0704 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0704 RECIPIENT MANAGEMENT LOCK-IN SYSTEM

(a) The Division shall have methods and procedures for the control of recipient overutilization of Medicaid benefits. These methods and procedures shall include Lock-In of a recipient, shown to be an overutilizer, to specified providers of health care and services, as set out in 42 C.F.R. 440.230, 440.260, and 431.54(e), which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/. ~~services.~~

(b) Prior to implementing Lock-In, ~~Lock-In~~ the following steps shall be taken:

(1) Recipient's utilization pattern shall ~~will~~ be documented as inappropriate;

(2) Recipient shall ~~will~~ be notified that the State is imposing a Lock-In procedure;

(3) Recipient shall ~~will~~ be offered the opportunity to select a provider;

(4) In the event the recipient fails to select a provider, a provider shall ~~will~~ be selected for him or her by the Division; ~~Division of Medical Assistance;~~ and

(5) Recipient shall ~~will~~ receive an eligibility card indicating the selected providers.

(c) Recipient utilization patterns shall ~~will~~ be reviewed ~~periodically~~ to determine if changes have occurred. If the utilization pattern has been corrected, the Lock-In status shall end; ~~will be ended;~~ if the utilization pattern remains inappropriate ~~aberrant,~~ Lock-In status shall continue. ~~will be continued.~~

(d) The Division may Lock-In a recipient provided:

(1) the~~The~~ recipient is given notice and an opportunity for a hearing before imposing restriction, pursuant to ~~state statutes governing appeals by public assistance~~ G.S. 150B-23; and ~~recipients.~~

(2) the~~The~~ Division assures that the recipient has reasonable access to Medicaid care and 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/.

History Note: *Authority G.S. 108A-25(b); 108A-64; 108A-79; 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; 42 C.F.R. Part 456;*
Eff. May 1, 1984; ~~1984.~~
Readopted Eff. July 1, 2018.

10A NCAC 22F .0706 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0706 RECOUPMENT OF RECIPIENT OVERPAYMENTS

The Division requires [~~shall oversee~~] ~~will ensure~~ that:

(1) counties recover ~~any and all~~ recipient responsible overpayments as a debt to the participating local governments;

(2) counties accept payments from each recipient and give the recipient a receipt for each transaction;

(3) counties keep a separate accounting for Medicaid repayments on each recipient;

(4) repayments shall be ~~are~~ forwarded to the Division of Medical Assistance utilizing the DMA 7050 form. This shall ~~must~~ be done ~~at least~~ on a monthly basis;

(5) the recoupment monies that are apportioned to the repayment of ~~usual adjustments to~~ federal, State, ~~state,~~ and county funds shall be ~~are~~ made by the State; ~~state;~~

(6) Medical Assistance overpayments shall not be ~~are not~~ recouped through the reduction of Temporary Assistance for Needy Families (TANF) checks; ~~check reduction;~~ and

(7) the Division receives its prorated share of recoupments of recipient overpayments involving multiple programs. ~~payments received from recipients with overpayments involving more than one program will be prorated so that the Medicaid program will receive its fair share of each payment.~~

History Note: *Authority G.S. 108A-25(b); 108A-64; 42 C.F.R. Part 431; 42 C.F.R. Part 455; 42 C.F.R. Part 456; Eff. May 1, 1984; ~~1984.~~*
Readopted Eff. July 1, 2018.

10A NCAC 22H .0203 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0203 INITIATING A HEARING

(a) In order to initiate an appeal of a facility's intent to transfer or discharge, a resident, ~~resident or~~ family member, ~~member~~ or legal representative shall submit a written request for a hearing to the Hearing Unit. The request for hearing shall ~~must~~ be received by the Hearing Unit within 11 calendar days from the date of the facility's notice of transfer or discharge. If the eleventh day falls on a Saturday, Sunday, ~~Sunday~~ or legal holiday, then the period during which an appeal may be requested shall run until the end of the next business day which is not a Saturday, Sunday, ~~Sunday~~ or legal holiday.

(b) The request for hearing shall be submitted to the Hearing Unit by mail, ~~or~~ facsimile, or hand delivery.

History Note: *Authority G.S. 108A-25(b); 42 USCS 1396r(e)(3), (f)(3); 42 C.F.R. Part 483, Subpart E; ~~483.12;~~*
Eff. April 1, 1994; ~~1994.~~
Readopted Eff. July 1, 2018.

10A NCAC 22H .0204 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0204 HEARING PROCEDURES

(a) Upon timely receipt of a request for a hearing of a transfer or discharge by a nursing facility ~~hearing,~~ as set out in Rule .0203 of this Section, the Hearing Unit shall ~~promptly~~ notify the parties ~~facility~~ of the request.

(b) The parties shall be notified by certified mail of the date, time, ~~time~~ and place of the hearing. Hearings shall be conducted by telephone, unless an in-person hearing is requested. If the hearing is to be conducted in person, it shall be held in Raleigh, North Carolina.

(c) ~~At least five working days prior to the hearing, the~~ The facility ~~administrator~~ shall make available to the resident all documents and records to be used at the hearing, to be received at least five business days prior to the hearing. ~~hearing.~~ The facility administrator shall forward identical information to the Hearing Unit, to be received at least five business ~~working~~ days prior to the hearing.

(d) The hearing officer may grant continuances for good cause. ~~continuances.~~ For purposes of this Rule, circumstances beyond the control of the party constitute good cause.

(e) The hearing officer shall ~~may~~ dismiss a request for hearing if the resident or family member or legal representative of the resident fails to appear at a scheduled hearing, unless good cause is shown. ~~hearing.~~

(f) The hearing officer shall ~~may~~ proceed to conduct a scheduled hearing if a facility representative fails to appear at a scheduled hearing.

(g) The Rules of Civil Procedures as contained in G.S. 1A-1 and the General Rules of Practice for the Superior and District Courts as authorized by G.S. 7A-34 and found in the Rules Volume of the North Carolina General Statutes shall not apply in any hearings held by a Division Hearing Officer. ~~Officer unless another specific statute or rule provides otherwise.~~ Division hearings are not contested case hearings within the meaning of G.S. 150B and shall not be governed by the provisions of that Chapter unless otherwise stated in these Rules. Parties may be represented by counsel or other representative at the hearing.

History Note: *Authority G.S. 108A-25(b); 42 USCS 1396r(e)(3), (f)(3); 42 C.F.R. Part 431, Subpart E; 42 C.F.R. Part 483, Subpart E; ~~483.12;~~*
Eff April 1, 1994; ~~1994.~~
Readopted Eff. July 1, 2018.

10A NCAC 22H .0205 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0205 HEARING OFFICER'S FINAL DECISION

(a) The Hearing Officer's final decision shall uphold or reverse the facility's decision regarding the transfer or discharge of a resident. ~~decision.~~ Copies of the final decision shall be mailed via certified mail to the parties.

(b) A party may appeal the Hearing Officer's final decision by filing a petition for judicial review in Wake County Superior Court or in the superior court of the county where the petitioner resides within 30 days of the date of the decision letter. [~~Service is made by the placing of the decision in an official depository of the United States Postal Service and addressed to the person or entity at the last address provided.~~] The Department as the decision maker in the appeal to the Hearing Unit shall not be a party of record.

History Note: *Authority G.S. 108A-25(b); 42 USCS 1396r(e)(3), (f)(3); 42 C.F.R. Part 483, Subpart E; ~~483.12;~~*
Eff. April 1,1994; ~~1994.~~
Readopted Eff. July 1, 2018.

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

10A NCAC 22H .0302 PASRR ~~PASARR~~ REQUIREMENTS

(a) The evaluated individual and family member or legal representative shall be notified in writing of the Division of MH/DD/SAS' PASRR ~~PASARR~~ determination under the provisions of 42 CFR 483.130 ~~483.130(k)~~ which is incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/. ~~amendments. A copy of 42 CFR 483.130(k) can be obtained from the Division of Medical Assistance at a cost of twenty cents ($0.20) per copy.~~

(b) The PASRR ~~PASARR~~ Notice of Determination form shall be used by Division of MH/DD/SAS when giving notice of a PASRR ~~PASARR~~ determination. ~~determination under~~ [~~the~~] ~~provisions of 42 CFR 483.130(l)(1-4) which is incorporated by reference with subsequent changes or~~ [~~amendments and available free of charge at https://www.ecfr.gov/.~~] ~~amendments. A copy of 42 CFR 483.130(l)(1-4) can be obtained from the Division of Medical Assistance at a cost of twenty cents ($0.20) per copy.~~

(c) The Division of MH/DD/SAS shall provide a Hearing Request ~~Request for Hearing~~ form, ~~pertinent~~ PASRR II Screening ~~Evaluation~~ form, and PASRR ~~PASARR~~ Notice of Determination form to the evaluated individual and legal representative under the provisions of 42 CFR 483.128(1) which is incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/. ~~amendments. A copy of 42 CFR 483.128(1) can be obtained from the Division of Medical Assistance at a cost of twenty cents ($0.20) per copy.~~

History Note: *Authority G.S. 108A-25(b); ~~[150B-21.6;]~~ 42 U.S.C.S. 1395i-3(e)(3), (f)(3); 1396r(e)(3), (e)(7)(F), (f)(3); 42 C.F.R. 483.5; 42 C.F.R. Part 483, Subparts C and E; ~~42 C.F.R. 483.12; 42 C.F.R. 483.128; 42 C.F.R. 483.130; 42 C.F.R. 483.200; 42 C.F.R. 483.204; 42 C.F.R. 483.206;~~*
Eff. October 1, 1994; ~~1994.~~
Readopted July 1, 2018.

10A NCAC 22H .0304 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0304 HEARING PROCEDURES

(a) Upon ~~timely~~ receipt of a Hearing Request Form to appeal a PASRR determination, [~~Form,~~] ~~request for a hearing,~~ the Hearing Unit shall notify the Division of MH/DD/SAS of the request.

(b) The parties shall be notified by certified mail of the date, time, ~~time~~ and place of the hearing. Hearings shall be conducted by telephone, unless an in-person hearing is requested. If the hearing is to be conducted in person, it shall be held in Raleigh, North Carolina.

(c) The Division of MH/DD/SAS shall mail all documents and records to be used at the hearing to the person requesting the hearing by certified mail and forward identical information to the Hearing Unit, to be received by both the requestor and the Hearing Unit at least five business ~~working~~ days prior to the hearing.

(d) The hearing officer may grant continuances for good cause. ~~continuances.~~ For purposes of this Rule, circumstances beyond the control of the party constitute good cause.

(e) The hearing officer shall ~~may~~ dismiss a request for a hearing if the evaluated individual or legal representative fails to appear at a scheduled hearing, unless good cause is shown. ~~hearing.~~

(f) The hearing officer shall ~~may~~ proceed to conduct a scheduled hearing if the Division of MH/DD/SAS fails to appear at a scheduled hearing.

(g) The Rules of Civil Procedure as contained in G.S. 1A-1 and the General Rules of Practice for the Superior and District Courts as authorized by G.S. 7A-34 and found in the Rules Volume of the North Carolina General Statutes shall not apply in any hearings held by the Division Hearing Officer. ~~Officer unless another specific statute or other rule provides otherwise.~~ Division hearings are not contested case hearings within the meaning of G.S. 150B and shall not be governed by the provisions of that chapter unless otherwise stated in these Rules. ~~The hearing officer may use the North Carolina Rules of Evidence for guidance in conducting hearings.~~ Parties may be represented by counsel or other representative at the hearing.

History Note: *Authority G.S. 108A-25(b); 42 U.S.C.S. 1395i-3(e)(3), ~~(e)(7)(F),~~ (f)(3); ~~42 U.S.C.S. 1396r(e)(3), [(e)(7)(F),] (f)(3);~~ 42 C.F.R. 431, Subpart E; ~~431.200;~~ 42 C.F.R. Part 483, Subpart E; ~~42 C.F.R. 483.200; 42 C.F.R. 483.204; 42 C.F.R. 483.206;~~*
Eff. October 1, 1994; ~~1994.~~
Readopted Eff. July 1, 2018.

10A NCAC 22H .0305 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0305 HEARING OFFICER'S FINAL DECISION

(a) The Hearing Officer's final decision shall uphold or reverse the Division of MH/DD/SAS' PASRR decision. Copies of the final decision shall be mailed via certified mail to the parties.

(b) A party may appeal the Hearing Officer's final decision by filing a petition for judicial review in Wake County Superior Court or in the superior court of the county where the petitioner resides within 30 days of the date of the decision letter. [~~Service is made by the placing of the decision in an official depository of the United States Postal Service and addressed to the person or entity at the last address provided.~~] The Division [~~Department~~] as the decision maker in the appeal to the Hearing Unit shall not be a party of record.

History Note: *Authority G.S. 108A-25(b); 42 U.S.C.S. 1395i-3(e)(3), ~~(e)(7)(F),~~ (f)(3); 42 U.S.C.S. 1396r(e)(3), (e)(7)(F), (f)(3); 42 C.F.R. 431.200; 42 C.F.R. Part 483, Subpart E; ~~42 C.F.R. 483.200; 42 C.F.R. 483.204; 42 C.F.R. 483.206;~~*
Eff. October 1, 1994; ~~1994.~~
Readopted Eff. July 1, 2018.

10A NCAC 22J .0102 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22J .0102 PETITION FOR RECONSIDERATION REVIEW

(a) A provider may request a reconsideration review within 30 calendar days from receipt of final notification of payment, payment denial, disallowances, payment adjustment, notice of program reimbursement, ~~reimbursement~~ and adjustments. ~~adjustments and~~ A provider may request a reconsideration review within 60 calendar days from receipt of notice of an institutional reimbursement rate. Final notification of payment, payment denial, disallowances and payment adjustment means that all administrative actions necessary to have a claim paid ~~correctly~~ have been taken by the provider and the Division ~~DMA~~ or the fiscal agent has issued a final adjudication. If no request is received within the respective 30 or 60 day periods, the Division's ~~state agency's~~ action shall become final.

(b) A request for reconsideration review shall ~~must~~ be in writing and signed by the provider or the provider's representative and contain the provider's name, address, ~~address~~ and telephone number. It shall ~~must~~ state the specific dissatisfaction with the Division's ~~DMA's~~ action and should be mailed to: Appeals, Division of Medical Assistance, 2501 Mail Service Center, Raleigh, North Carolina 27699-2501. ~~Assistance at the Division's current address.~~

(c) The provider may appoint another individual to represent him. A written statement setting forth the name, address, ~~address~~ and telephone number of the representative so designated shall be sent to the address listed in paragraph (b) of this Rule. ~~above address.~~ The representative may exercise any ~~and all~~ rights given the provider in the review process. Notice of meeting dates, requests for information, or hearing decisions ~~decisions, etc. will~~ shall be sent to the authorized representative. Copies of such documents shall ~~will~~ be sent to the petitioner only if a written request is made.

History Note: *Authority G.S. 108A-25(b); 108A-54; ~~150B-11;~~ 42 U.S.C. 1396b; 42 C.F.R. 455.512;*
Eff. January 1, 1988; ~~1988.~~
Readopted Eff. July 1, 2018.

10A NCAC 22J .0103 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22J .0103 RECONSIDERATION REVIEW PROCESS

(a) Upon receipt of a ~~timely~~ request for a reconsideration review that is submitted timely pursuant to Rule .0102 of this Subchapter, ~~review,~~ the Deputy Director shall appoint a reviewer or panel to conduct the review. The Division shall ~~DMA will~~ arrange with the provider a time and date of the hearing. The provider shall ~~must~~ reduce his arguments to writing and submit them to the Division ~~DMA~~ no later than 14 calendar days prior to the review. Failure to submit written arguments within this time frame shall be grounds for dismissal of the reconsideration, unless the Division within the 14 calendar day period agrees to a delay for good cause. ~~delay.~~ For purposes of this Rule, "good cause" is an action uncontrollable by the provider.

(b) The provider shall ~~will~~ be entitled to an in-person ~~a personal~~ review meeting unless the provider agrees to a review of documents only or a discussion by telephone.

(c) Following the review, the Division ~~DMA~~ shall, within 30 calendar days or such additional time thereafter as specified in writing during the 30 day period, render a decision in writing and send it by certified mail to the provider or his representative.

History Note: *Authority G.S. 108A-25(b); 108A-54; ~~150B-11;~~ 42 U.S.C. 1396b; 42 C.F.R. 455.512;*
Eff. January 1, 1988;
Pursuant to G.S. 150B-33(b)(9), Administrative Law Judge Augustus B. Elkins, II declared this rule void as applied in Psychiatric Solutions, Inc., d/b/a/ Holly Hill Hospital v. Division of Medical Assistance, North Carolina Department of Health and Human Services (02 DHR 1499); ~~1499).~~
Readopted Eff. July 1, 2018.

10A NCAC 22K .0102 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22K .0102 AGREEMENT

(a) The provider ~~must~~ shall ~~agree to~~ participate in training offered by the Division ~~of Medical Assistance (DMA)~~ or its agents and ~~to~~ make presumptive eligibility determinations in accordance with [~~pursuant to~~] 42 C.F.R. 435.1103, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/, and the Medicaid State Plan.~~based on the procedures and guidelines issued by the DMA.~~

(b) The Division ~~DMA may~~ shall terminate the provider's Medicaid Participation agreement and authority to make presumptive determinations if the provider fails to make required notifications to the county department of social services in the pregnant woman's county of residency ~~referrals~~ within five business days or fails to follow procedures set forth in the Medicaid State Plan, ~~[Section MA3245 of the Department of Health and Human Service's Family and Children's Medical Manual, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www2.ncdhhs.gov/info/olm/manuals/dma/fcm/man/ma3245-01.htm,]~~~~procedures and guidelines~~ resulting in eligibility denials for a majority of the provider's referrals.

(c) Termination of the agreement ~~will~~ shall occur 30 calendar days following notification when termination is initiated by the Division. ~~DMA.~~

History Note: *Authority G.S. 108A-25(b); 42 U.S.C. 1396r–1; 42 C.F.R. 435.1103; ~~1987 Session Laws, c. 738; P.L. 99-509;~~*
Eff. June 1, 1988; ~~1988.~~
Readopted Eff. July 1, 2018.

10A NCAC 22L .0102 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22L .0102 COORDINATION FEE

In addition to normal Medicaid payments, the Division ~~of Medical Assistance~~ ~~has the authority to~~ may pay participating physicians a monthly fee to provide case management ~~coordination fee~~ for providing or coordinating the health care services of enrollees who have selected them as their primary care physician.

History Note: *Authority G.S. 108A-25(b);* ~~*Section 93(h) of Chapter 689, 1991 North Carolina Session laws;*~~
Eff. August 3, 1992. ~~*1992.*~~
Readopted Eff. July 1, 2018.

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

10A NCAC 22L .0104 ENROLLMENT

All Medicaid beneficiaries ~~recipients~~ in participating counties who are eligible for ~~Carolina ACCESS~~primary care case management shall enroll. ~~enroll in Carolina ACCESS.~~ Eligible Medicaid beneficiaries ~~recipients eligible for Carolina ACCESS~~ include ~~AFDC,~~ AFDC-related, MIC, Aged, Blind and Disabled categories, unless exempt due to institutional placement. Institutional placement includes nursing home, mental institutions, ~~institutions~~ and domiciliary care. The following beneficiaries have the option to enroll in primary care case management: Medicaid for Pregnant Women, benefit diversion beneficiaries, beneficiaries with end stage renal disease, and Native Americans/Alaska Natives. ~~Medicaid recipients who are Medicaid Pregnant Women, foster children or who are also on Medicare, have the option to enroll in Carolina ACCESS.~~

(a) All Medicaid beneficiaries ~~recipients~~ in participating counties who are eligible for ~~Carolina ACCESS~~primary care case management shall enroll. ~~enroll in Carolina ACCESS.~~ Eligible Medicaid beneficiaries ~~recipients eligible for Carolina ACCESS~~ include ~~AFDC,~~ AFDC-related, MIC, Aged, Blind and Disabled categories, unless exempt due to institutional placement. Institutional placement includes nursing home, mental institutions, ~~institutions~~ and domiciliary care.

(b) The following beneficiaries have the option to enroll in primary care case management:

(1) Medicaid for Pregnant Women; [~~Women,~~]

(2) benefit diversion beneficiaries; [~~beneficiaries,~~]

(3) beneficiaries with end stage renal disease; and [~~disease,~~]

(4) [~~and~~] Native Americans/Alaska Natives. [~~Natives.~~]

~~Medicaid recipients who are Medicaid Pregnant Women, foster children or who are also on Medicare, have the option to enroll in Carolina ACCESS.~~

History Note: *Authority G.S. 108A-25(b); ~~Section 93(h) of Chapter 689, 1991 North Carolina Session laws;~~*
Eff. August 3, 1992; ~~1992.~~
Readopted July 1, 2018.

10A NCAC 22N .0203 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22N .0203 ENROLLMENT RESTRICTIONS

(a) The Department shall deny enrollment, including enrollment for new or additional services in accordance with G.S. 122C-23(e1) and G.S. 131D-10.3(h). ~~They may be accessed online at http://www.ncleg.net/statutes/generalstatutes/html/bysection/chapter_122c/gs_122c-23.html and http://www.ncleg.net/statutes/generalstatutes/html/bysection/chapter_131d/gs_131d-10.3.html.~~

(b) The Department may deny enrollment when an applicant meets any of the following conditions:

(1) if the Department has initiated revocation or summary suspension proceedings against any facility licensed pursuant to G.S. 122C, Article 2, G.S. 131D, Articles 1 or 1A, or G.S. 110, Article 7 ~~which~~ that was previously held by the applicant and the applicant voluntarily relinquished the license;

(2) there is a pending appeal of a denial, revocation, ~~revocation~~ or summary suspension of any facility licensed pursuant to G.S. 122C, Article 2, G.S. 131D, Articles 1 or 1A, or G.S. 110, Article 7 ~~which~~ that is owned by the applicant;

(3) the applicant had an individual as part of their governing body or management who previously held a license ~~which~~ that was revoked or summarily suspended under G.S. 122C, Article 2, G.S. 131D, Articles 1 or 1A, and G.S. 110, Article 7 and the rules adopted under these laws; or

(4) the applicant is an individual who has a finding or pending investigation by the Health Care Personnel Registry in accordance with G.S. 131E -256.

(c) When an application for enrollment of a new service is denied:

(1) pursuant ~~Pursuant~~ to G.S. 150B-22, the applicant shall be given an opportunity to provide reasons why the enrollment should be granted or the matter otherwise settled;

(2) the Division ~~DMA~~ shall give the applicant written notice of the denial, the reasons for the denial and advise the applicant of the right to request a contested case hearing pursuant to G.S. 150B; and

(3) the ~~The~~ provider shall not provide the new service until a decision is made to enroll the provider, despite an appeal action.

(d) If the ~~action~~ denial is reversed on appeal, the ~~owner~~ provider may re-apply for enrollment in accordance with 42 C.F.R. 455, Subpart E, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/. ~~and may be approved back to the date of the denied application if all qualifications are met.~~

History Note: *Authority G.S. 108A-54; 143B-139.1;122C-23(e1),(e3); 131E-256; 110, Article 7; 42 C.F.R. 455.422; 42 C.F.R. 1002.213;*
Eff. July 1, 2004; ~~2004.~~
Readopted Eff. July 1, 2018.