

CHAPTER 22 - MEDICAL ASSISTANCE ELIGIBILITY

SUBCHAPTER 22A – IDENTIFYING INFORMATION

10A NCAC 22A .0101 SCOPE

The Division of Health Benefits shall administer and supervise the administration of medical services under Title XIX of the Social Security Act, commonly referred to as Medicaid. A fiscal agent, under contract to the Department of Health and Human Services, shall process claims for medical services, and conduct utilization control activities. Payment of claims shall be made to the providers. Notwithstanding any other rules in this Chapter, no services shall be covered for which funds have not been allocated by the General Assembly.

*History Note: Authority G.S. 108A-25(b); 108A-54;
Eff. February 1, 1976;
Amended Eff. September 30, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;
Amended Eff. March 1, 2020.*

10A NCAC 22A .0102 RESERVED FOR FUTURE CODIFICATION

SUBCHAPTER 22B – PROVIDER ISSUES

SECTION .0100 - GENERAL

10A NCAC 22B .0101 INSTITUTIONAL HEALTH SERVICES

No provider shall be enrolled in the Medicaid Program to provide any new institutional health service for which a Certificate of Need is required under G.S. 131E, Article 9 without first obtaining a Certificate of Need and meeting the conditions imposed by it.

*History Note: Authority G.S. 108A-25(b); 108A-54;
Eff. March 1, 1993;
Recodified from 10 NCAC 26B .0124 Eff. October 1, 1993;
Recodified from 10 NCAC 26B .0125 Eff. April 1, 1994;
Recodified from 10 NCAC 26B .0126 Eff. January 1, 1998;
Readopted Eff. July 1, 2018.*

10A NCAC 22B .0102 COORDINATION WITH TITLE XVIII

The entire range of benefits under Part B of Title XVIII 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/>, to Medicare-eligible persons shall be provided through a buy-in agreement with the Secretary of Health and Human Services. This agreement shall cover all persons eligible under the Medicaid State Plan.

*History Note: Authority G.S. 108A-25(b); 108A-54;
Eff. February 1, 1976;
Readopted Eff. October 31, 1977;
Amended Eff. June 1, 1998;
Readopted Eff. July 1, 2018.*

10A NCAC 22B .0103 INSTITUTIONAL STANDARDS

Institutions shall 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/>. These standards are set forth in North Carolina licensing law and federal

regulations, and are kept on file in the Department of Health and Human Services, Division of Health Services Regulation 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;
Eff. February 1, 1976;
Readopted Eff. October 31, 1977;
Readopted Eff. July 1, 2018.

10A NCAC 22B .0104 TIME LIMITATION

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

- (1) within 365 days of the date of service for services other than inpatient hospital, home health, or nursing home services;
- (2) 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, 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/>; or
- (3) within 180 days of the Medicare or other third party payment or final denial, when the date of the third party payment or denial exceeds the filing limits in Subparagraphs (1) or (2) of this Paragraph, if it is shown that:
 - (A) a claim was filed with a prospective third-party payor within the filing limits in Subparagraph (1) or (2) of this Paragraph;
 - (B) payment from the third party payor with whom the claim was filed is pending; and
 - (C) documented efforts were made to achieve either payment or final denial of the third-party claim.

(b) Providers shall 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 be waived by the Division when there is a correction of an administrative error in determining eligibility by the county or 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, the provider may request a reconsideration review by the Director of the Division. "Good cause" is an action outside the control of the provider. The Director of the Division shall be 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;
Readopted Eff. July 1, 2018.

10A NCAC 22B .0105 OVERUTILIZER IDENTIFICATION

History Note: Authority G.S. 108A-25(b);
Eff. January 1, 1978;
Amended Eff. May 1, 1990; October 4, 1979;
Repealed Eff. July 1, 2018.

SECTION .0200 - MANUALS AND FORMS

10A NCAC 22B .0201 MANUALS

Manuals and bulletins explaining Medicaid procedures are available through the private contractor mentioned in 10A NCAC 22A .0101.

History Note: Authority G.S. 108A-25(b);
Eff. February 1, 1976;
Readopted Eff. October 31, 1977;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015.

10A NCAC 22B .0202 FORMS

All forms are available through the private contractor mentioned in 10A NCAC 22A .0101.

History Note: Authority G.S. 108A-25(b); 108A-54; 143B-10;
Eff. February 1, 1976;
Readopted Eff. October 31, 1977;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015.

SUBCHAPTER 22C – AMOUNT: DURATION: AND SCOPE OF ASSISTANCE

10A NCAC 22C .0101 COST SHARING **10A NCAC 22C .0102 MEDICALLY NEEDY** **10A NCAC 22C .0103 CATEGORICALLY NEEDY**

History Note: Authority G.S. 108A-25(b); S.L. 1985, c. 479, s. 86; 34 C.F.R. 447.50; 42 C.F.R. 440.210; 42 C.F.R. 440.220; 42 C.F.R. 440.240;
Eff. February 1, 1976;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1990;
Repealed Eff. July 1, 2018.

10A NCAC 22C .0104 HEALTH INSURING ORGANIZATIONS

History Note: Authority G.S. 108A-25(b); 34 C.F.R. 434.14;
Eff. February 1, 1976;
Readopted Eff. October 31, 1977;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

SUBCHAPTER 22D – RECIPIENT ISSUES

10A NCAC 22D .0101 CO-PAYMENT

History Note: Authority G.S. 108A-25(b); S.L. 1985, c. 479, s. 86; 42 C.F.R. 440.230(d);
Tax Equity and Fiscal Responsibility Act of 1982, Subtitle B; Section 95 of Chapter 689, 1991 Session Laws;
Eff. January 1, 1984;
Temporary Amendment Eff. August 15, 1991 For a Period of 180 Days to Expire on February 15, 1992;
Amended Eff. February 1, 1992;
Temporary Amendment Eff. September 15, 1992 For a Period of 180 Days or Until the Permanent Rule Becomes Effective, Whichever is Sooner;
Amended Eff. February 1, 1993;

Temporary Amendment Eff. January 1, 2002;
Amended Eff. April 1, 2003;
Repealed Eff. July 1, 2018.

SUBCHAPTER 22E - COOPERATIVE AGREEMENTS

10A NCAC 22E .0101 DEPARTMENT OF ENVIRONMENT AND NATURAL RESOURCES

History Note: Authority G.S. 108A-25(b); 143B-10;
Eff. February 1, 1976;
Readopted Eff. October 31, 1977;
Amended Eff. August 1, 1990;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22E .0102 VOCATIONAL REHABILITATION

The cooperative agreements between the Divisions of Medical Assistance and Vocational Rehabilitation, Department of Health and Human Services, shall commit the Divisions to their responsibilities with regard to social services and medical services.

History Note: Authority G.S. 108A-25(b); 143B-10; 143B-138;
Eff. February 1, 1976;
Readopted Eff. October 31, 1977;
Amended Eff. August 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015.

10A NCAC 22E .0103 MENTAL HEALTH, DEVELOP/DISABILITIES/SUBSTANCE ABUSE SVCS

The cooperative agreements between the Divisions of Health Benefits and Mental Health, Developmental Disabilities and Substance Abuse Services, Department of Health and Human Services, shall commit the Divisions to their responsibilities with regard to social services.

History Note: Authority G.S. 108A-25(b); 143B-10; 143B-138;
Eff. February 1, 1976;
Readopted Eff. October 31, 1977;
Amended Eff. August 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;
Amended Eff. March 1, 2020.

10A NCAC 22E .0104 FACILITY SERVICES

10A NCAC 22E .0105 BLUE CROSS AND BLUE SHIELD

History Note: Authority G.S. 108A-25(b); 143B-10;
Eff. November 1, 1977;
Amended Eff. August 1, 1990;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

SUBCHAPTER 22F - PROGRAM INTEGRITY

SECTION .0100 - GENERAL

10A NCAC 22F .0101 SCOPE

This Subchapter shall provide methods and procedures to ensure the integrity of the Medicaid program. Nothing in these procedures is intended, nor shall be construed, to grant any provider any right to participate in the Medicaid program not granted by federal law or regulations.

History Note: Authority G.S. 108A-25(b); 108A-63; 108A-64; 42 C.F.R. 455.1;
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1990; May 1, 1984;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015.

10A NCAC 22F .0102 ORGANIZATION

The North Carolina Department of Health and Human Services, Division of Health Benefits shall perform the duties required by this Subchapter. The Department or Division may enter into contracts with other persons for the purpose of performing these duties.

History Note: Authority G.S. 108A-25(b); 42 C.F.R. Part 455;
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1984;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;
Amended Eff. March 1, 2020.

10A NCAC 22F .0103 FUNCTIONS

(a) The Division shall develop, implement and maintain methods and procedures for preventing, detecting, investigating, reviewing, hearing, referring, reporting, and disposing of cases involving fraud, abuse, error, overutilization or the use of medically unnecessary or medically inappropriate services.

(b) The Division shall institute methods and procedures to:

- (1) receive and process complaints and allegations of provider and recipient aberrant practices;
- (2) perform preliminary and full investigations to collect facts, data, and information;
- (3) analyze and evaluate data and information to establish facts and conclusions concerning provider and recipient practices;
- (4) make administrative decisions affecting providers, including but not limited to suspension from the Medicaid program;
- (5) recoup improperly paid claims;
- (6) establish remedial measures including but not limited to monitoring programs;
- (7) conduct administrative review or, when legally necessary, hearings except as provided in Subparagraph (b)(8) of this Rule;
- (8) refer for provider peer review those cases involving questions of professional practice.

History Note: Authority G.S. 108A-25(b); 108A-63; 108A-64; 42 C.F.R. 455, Subpart A;
Eff. May 1, 1984;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015.

10A NCAC 22F .0104 PREVENTION

(a) Provider Education. Upon the request of a provider, the Division may conduct on-site educational visits to assist a provider in complying with requirements of the Medicaid Program.

(b) Provider Manuals. The Division shall prepare and make available 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 check eligibility, duplicate payments, third party liability, and unauthorized or uncovered services by means of prepayment review, computer edits and audits, and investigation.
- (d) Prior Approval. The Division shall require prior approval for certain specified covered services as set forth in the Medicaid State Plan.
- (e) Claims. The following terms and conditions shall apply to the submission of claims:
- (1) Medicaid payment shall constitute payment in full;
 - (2) charges to Medicaid recipients for the same items and services shall not be higher than for private paying patients;
 - (3) the provider shall keep all records as necessary to support the services claimed for reimbursement;
 - (4) the provider shall disclose the contents of his Medicaid financial and medical records to the Division and its agents; and
 - (5) Medicaid reimbursement shall only be made for medically necessary care and services as defined in 10A NCAC 25A .0201.
- (f) Provider Administrative Participation Agreements. All providers shall execute a written participation agreement as a condition for participating in the N.C. State Medicaid Program.
- (g) The Recipient Management LOCK-IN System. The Division 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 refer the recipient to other physicians as medically necessary, as defined in 10A NCAC 25A .0201.

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; Readopted Eff. September 1, 2018.

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; Repealed Eff. July 1, 2018.

10A NCAC 22F .0106 CONFIDENTIALITY

All investigations by the Division 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-54; 108A-54.1B; 132-1.4; 42 C.F.R. Part 455; 42 C.F.R. 455.21; Eff. May 1, 1984; Amended Eff. May 1, 1990; Readopted Eff. July 1, 2018.

10A NCAC 22F .0107 RECORD RETENTION

All Title XIX and Title XXI providers shall keep and maintain all Medicaid and NC Health Choice financial, medical, or other records necessary to disclose the nature and extent of services furnished to Medicaid and NC Health Choice recipients and claimed for reimbursement. These records shall be retained for a period of not less than five full years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or data retention agreements. Upon notification of an audit or upon receipt of a request for records, all records related to the audit or records request shall be retained until notification that the investigation has been concluded.

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-63; 108A-64; 42 C.F.R. Part 455; 42 C.F.R. 455.12–23; 42 C.F.R. 431.107; Eff. April 1, 1988; Readopted Eff. July 1, 2018.

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; 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;
Repealed Eff. July 1, 2018.

10A NCAC 22F .0202 INVESTIGATION

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

- (1) whether there are sufficient findings to warrant a full investigation, as set out in Paragraph (b) of this Rule;
- (2) whether there is sufficient evidence to warrant referring the case for civil fraud investigation, criminal fraud investigation, or both; or
- (3) whether there is insufficient evidence to support the allegation(s) and the case may be closed.

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

- (1) the case is found to be one of program abuse subject to administrative action, pursuant to Rule .0602 of this Subchapter;
- (2) the case is closed for insufficient evidence of fraud or abuse; or
- (3) 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; Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1984;
Readopted Eff. July 1, 2018.

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

The Division shall refer credible allegations of 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/>, or suspected physical abuse of recipients to the State Medicaid Fraud Control Unit or other law enforcement agency.

History Note: Authority G.S. 108A-25(b); 108A-63; P.L. 95-142; 42 C.F.R. 455.2; 42 C.F.R. 455.14; 42 C.F.R. 455.15;
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1984;
Readopted Eff. July 1, 2018.

SECTION .0300 - PROVIDER ABUSE

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

Program abuse by providers as used in this Chapter consists of incidents, services, or practices inconsistent with accepted fiscal or medical practices which cause financial loss to the Medicaid program or its beneficiaries, or which are not reasonable or which are not necessary, including:

- (1) billing for care or services at a frequency or amount that is not medically necessary, as defined by 10A NCAC 25A .0201;
- (2) separate billing for care and services that are:
 - (a) part of an all-inclusive procedure; or
 - (b) included in the daily per-diem rate;

- (3) billing for care and services that are provided by an 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;
- (4) failure to provide and maintain, within accepted medical standards for the community, quality of care;
- (5) failure to provide and maintain within accepted medical standards for the community, as set out in 10A NCAC 25A .0201, medically necessary care and services;
- (6) 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;
- (7) abuse as defined by 42 C.F.R. 455.2, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at <https://www.ecfr.gov/>;
- (8) cause for termination as described in 42 C.F.R. 455.101, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at <https://www.ecfr.gov/>;
- (9) violations of State and federal Medicaid statutes, federal Medicaid regulations, the rules of this Subchapter, the State Medicaid Plan, and Medicaid Clinical Coverage policies;
- (10) failure to notify the Division of Health Benefits (Division) within 30 calendar days of learning of any adverse action initiated against any required license, certification, registration, accreditation, or endorsement of the provider or any of its officers, agents, or employees;
- (11) billing the Medicaid beneficiary or any other person for items and services reimbursed by the Division;
- (12) discounting client accounts to a third party agent or paying a third party agent a percentage of the amount collected;
- (13) failure to refund any monies received in error to the Division within 30 calendar days of discovery;
- (14) failure to file mandatory reports or required disclosures with the Division within the time-frames established in federal or state statute, rule, or regulation;
- (15) billing for claims that are inaccurate, incomplete, or not personally provided by the provider, its employees, or persons with whom the provider has contracted to render services, under its direction;
- (16) billing for services provided at or from a site location not associated with the approved provider number, except for hospital services as set forth in 42 C.F.R. 413.65;
- (17) failure to notify the Division in writing of any change in information contained in the Medicaid provider enrollment application within 30 calendar days of the event triggering the reporting obligation;
- (18) failure to retain or submit to the Division upon request documentation for services billed to the Division;
- (19) failure to grant the Division access to provider facilities upon the Division's request; or
- (20) failure to perform services or supply goods in accordance with all requirements under Title VI of the Civil Rights Act of 1964, Section 504 of the 1973 Rehabilitation Act, the 1975 Age Discrimination Act, the 1990 Americans With Disabilities Act, Section 1557 of the Affordable Care Act, and all applicable federal and state statutes, rules, and regulations relating to the protection of human subjects of research.

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 108A-54.2; 108A-63; 42 C.F.R. Part 455; Eff. April 15, 1977;
 Readopted Eff. October 31, 1977;
 Amended Eff. May 1, 1984;
 Readopted Eff. June 15, 2020.

10A NCAC 22F .0302 INVESTIGATION

- (a) Fraud, waste, abuse, error, or practices not conforming to state and federal Medicaid laws and regulations, clinical coverage policies, 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 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. 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.

(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 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, 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; 42 CFR 455.412;
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1988; May 1, 1984;
Readopted Eff. September 1, 2018.

SECTION .0400 – AGENCY RECONSIDERATION REVIEW

10A NCAC 22F .0401 PURPOSE

History Note: Authority G.S. 108A-25(b); 42 C.F.R. 456;
Eff. December 1, 1982;
Transferred and Recodified from 10 NCAC 26I .0201 Eff. July 1, 1995;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;
Repealed Eff. July 1, 2018.

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.

(b) The provider shall be instructed to submit to the Division in writing a request for a Reconsideration Review within 30 business 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 Division's final decision.

(c) The Notice of Reconsideration Review shall be sent to the provider within 30 business days from receipt of the request. The provider shall be notified in writing to appear at a specified day, time, and place. The provider may be accompanied by legal counsel if the provider 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) The purpose of the Reconsideration Review includes:

- (1) clarification formulation, and simplification of issues;
- (2) exchange and full disclosure of information and materials;
- (3) review of the investigative findings;
- (4) resolution of matters in controversy;
- (5) consideration of mitigating and extenuating circumstances;
- (6) reconsideration of the administrative measures to be imposed; and
- (7) reconsideration of the restitution of overpayments.

(f) The Reconsideration Review decision shall be sent to the provider, in writing by certified mail, within 30 business 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. The decision shall state that the provider may request a contested case hearing in accordance with G.S. 150B, Article 3 and 26 NCAC 03 .0103. 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. 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.

History Note: Authority G.S. 108A-25(b); 108A-54; 150B, Article 3; S.L. 2011-375, s. 2; 42 C.F.R. Part 455.512;
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;
Readopted Eff. July 1, 2018.

10A NCAC 22F .0403 PROCESS

History Note: Authority G.S. 108A-25(b); 42 C.F.R. 456;
Eff. December 1, 1982;
Amended Eff. January 1, 1988; January 1, 1986;
Transferred and Recodified from 10 NCAC 26I .0202 Eff. July 1, 1995;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

SECTION .0500 - PEER REVIEW

- 10A NCAC 22F .0501 GENERAL**
- 10A NCAC 22F .0502 PEER REVIEW ESTABLISHED**
- 10A NCAC 22F .0503 CHOICE OF PROCEDURES**
- 10A NCAC 22F .0504 COMPOSITION OF PEER REVIEW BOARD**
- 10A NCAC 22F .0505 NOTICE OF PEER REVIEW**

History Note: Authority G.S. 108A-25(b); 150B-11; 42 C.F.R. Part 455; 42 C.F.R. Part 456;
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1990; January 1, 1987; January 1, 1986; May 1, 1984;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

- 10A NCAC 22F .0506 VENUE**
- 10A NCAC 22F .0507 DOCUMENTATION**
- 10A NCAC 22F .0508 PEER REVIEW PROCEDURES**
- 10A NCAC 22F .0509 DISQUALIFICATION OF BOARD MEMBERS**
- 10A NCAC 22F .0510 FAILURE OF PROVIDER TO ATTEND THE REVIEW**

History Note: Authority G.S. 108A-25(b); 150B-11; 42 C.F.R. Part 455; 42 C.F.R. Part 456;
Eff. May 1, 1984;
Amended Eff. May 1, 1990; September 1, 1988; January 1, 1987;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

SECTION .0600 – ADMINISTRATIVE SANCTIONS AND RECOUPMENT

10A NCAC 22F .0601 RECOUPMENT

(a) The Division shall seek full restitution of improper payments, as defined by 42 C.F.R. 431.958, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at <https://www.ecfr.gov/>, made to providers by the Medicaid Program. Recovery may be by lump sum payment, by a negotiated payment schedule, or by withholding from the provider's pending claims the total or a portion of the recoupment amount.

(b) A provider may seek reconsideration review of a recoupment imposed by the division under Rule .0402 of this Subchapter.

History Note: Authority G.S. 108A-25(b); 108C-5(g); 42 C.F.R. Part 431, Subpart Q; 42 C.F.R. Part 455, Subpart F; 42 C.F.R. Part 456; Eff. February 1, 1982; Amended Eff. May 1, 1984; Readopted Eff. July 1, 2018.

10A NCAC 22F .0602 ADMINISTRATIVE ACTIONS

(a) The following types of administrative actions may be imposed in any particular order by the Division in instances of program abuse by providers:

- (1) warning letters for instances of abuse that can be settled by issuing a warning to cease the specific abuse. The letter shall state that any further violations shall result in administrative or legal action initiated by the Division;
- (2) 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 findings have been made by the Division that this action shall 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/>;
- (3) termination of a provider from further participation in the Medicaid Program, subject to appeal rights under G.S. 150B, Article 3, provided that findings have been made by the Division that this action shall 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/>;
- (4) probation whereby a provider's participation is monitored for a specified period of time not to exceed one year, subject to appeal rights under G.S. 150B, Article 3. At the termination of the probation period the Division shall 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;
- (5) negotiation of a financial settlement with the provider;
- (6) placing the provider on prepayment review in accordance with G.S. 108C-7; or
- (7) establishing a monitoring program not to exceed one year whereby the provider shall comply with pre-established conditions of participation to allow review and evaluation of the provider's Medicaid claims.

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

- (1) seriousness of the offense;
- (2) extent of violations found;
- (3) history of prior violations;
- (4) prior imposition of sanctions;
- (5) 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, the Division shall notify the licensing board or other certifying group governing the sanctioned provider, federal and state agencies, and 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; Readopted Eff. September 1, 2018; Amended Eff. March 1, 2020.

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, from participating in the Medicaid program, provided 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/>.

(b) Suspension or termination from participation of any provider shall preclude the provider from submitting claims for payment to the Division. 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;
Readopted Eff. September 1, 2018.

10A NCAC 22F .0604 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. 455.23;
Eff. May 1, 1984;
Amended Eff. December 1, 1995;
Repealed Eff. September 1, 2018.

10A NCAC 22F .0605 TERMINATION

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

10A NCAC 22F .0606 TECHNIQUE FOR PROJECTING MEDICAID OVERPAYMENTS

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-63; 42 C.F.R. Part 455, Subpart F;
Eff. October 1, 1987;
Temporary Amendment Eff. November 8, 1996;
Amended Eff. August 1, 1998;
Repealed Eff. July 1, 2018.

SECTION .0700 – RECIPIENT FRAUD AND ABUSE

10A NCAC 22F .0701 DEFINITION OF FRAUD AND ABUSE

(a) For purposes of this Section the word "person" includes any natural person, association, consortium, corporation, body politic, partnership, or other group, entity or organization.

(b) Abuse. The type of abuse to which the Medicaid program is extremely vulnerable is recipient overutilization of medical and health care services for which he or she is eligible. A recipient may be regarded as overutilizing the program care and services if he or she has been furnished covered items or services at a frequency or amount not medically necessary, as determined in accordance with utilization guidelines established by the State, and the services were furnished at the request of the recipient.

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;
Amended Eff. May 1, 1990;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015.

10A NCAC 22F .0702 GENERAL

The Division will establish a statewide program for the prevention, detection, investigation, referral, prosecution, recoupment of overpayments, and reporting of fraud, abuse, and overutilization due to recipient aberrant practices. The program will be supervised by the Division and administered by the county departments of social services.

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; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015.

10A NCAC 22F .0703 WARNING NOTIFICATION

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; Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

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/>.

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

- (1) Recipient's utilization pattern shall be documented as inappropriate;
- (2) Recipient shall be notified that the State is imposing a Lock-In procedure;
- (3) Recipient shall be offered the opportunity to select a provider;
- (4) In the event the recipient fails to select a provider, a provider shall be selected for him or her by the Division; and
- (5) Recipient shall receive an eligibility card indicating the selected providers.

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

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

- (1) the recipient is given notice and an opportunity for a hearing before imposing restriction, pursuant to G.S. 150B-23; and
- (2) the Division assures that the recipient has reasonable access to Medicaid care and services of adequate 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; Readopted Eff. July 1, 2018.

10A NCAC 22F .0705 OVERUTILIZATION SURVEILLANCE (SUR INDICATOR)

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; Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22F .0706 RECOUPMENT OF RECIPIENT OVERPAYMENTS

The Division requires that:

- (1) counties recover 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 forwarded to the Division of Health Benefits utilizing the DMA 7050 form. This shall be done on a monthly basis;
- (5) the recoupment monies that are apportioned to the repayment of federal, State, and county funds shall be made by the State;
- (6) Medical Assistance overpayments shall not be recouped through the reduction of Temporary Assistance for Needy Families (TANF) checks; and
- (7) the Division receives its prorated share of recoupments of recipient overpayments involving multiple programs.

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;
Readopted Eff. July 1, 2018;
Amended Eff. March 1, 2020.

10A NCAC 22F .0707 REPORTS AND REVIEWS

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;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

SUBCHAPTER 22G – REIMBURSEMENT PLANS

SECTION .0100 – REIMBURSEMENT FOR NURSING FACILITY SERVICES

10A NCAC 22G .0101 REIMBURSEMENT PRINCIPLES

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 1985, c. 479, s. 86; 42 C.F.R. 447, Subpart C;
Eff. January 1, 1978;
Amended Eff. March 22, 1978;
Emergency Amendment [(a), (b), (c), (g), (m), (o), (p), (q)] Eff. April 1, 1978 for a Period of 120 Days to Expire on July 30, 1978;
Emergency Amendment [(a), (b), (c), (g), (m), (o), (p), (q)] Expired Eff. July 30, 1978;
Amended Eff. August 1, 1982;
Temporary Amendment Eff. October 1, 1984 for a Period of 120 Days to Expire on January 28, 1985;
Amended Eff. April 1, 1992; October 1, 1991; January 28, 1985;
Temporary Amendment Eff. June 26, 2003;
Temporary Amendment Expired April 27, 2004;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0102 RATE SETTING METHODS

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; 29 C.F.R. 1910, Subpart Z; 42 C.F.R. 447, Subpart C; S.L. 1991, c. 689, s. 95;
Eff. January 1, 1978;

Temporary Amendment Eff. October 1, 1984 for a Period of 120 Days to Expire on January 28, 1985;
Temporary Amendment Eff. October 1, 1991 for a Period of 180 Days to Expire on March 31, 1992;
Amended Eff. April 1, 1992;
Temporary Amendment Eff. July 1, 1992 for a Period of 180 Days to Expire on December 31, 1992;
Amended Eff. May 1, 1995; February 1, 1993; January 1, 1993;
Temporary Amendment Eff. January 22, 1998;
Amended Eff. April 1, 1999;
Temporary Amendment Eff. November 9, 2001;
Temporary Amendment Expired August 30, 2002;
Amended Eff. April 1, 2003;
Temporary Amendment Eff. August 3, 2004;
Amended Eff. January 1, 2005;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0103 REASONABLE AND NON-ALLOWABLE COSTS

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 1985, c. 479, s. 86; 42 C.F.R. 447, Subpart C; Eff. January 1, 1978;
Temporary Amendment Eff. October 1, 1984 for a Period of 120 Days to Expire on January 28, 1985;
Amended Eff. January 4, 1993; October 1, 1991; November 1, 1988; January 28, 1985;
Temporary Amendment Eff. August 3, 2004;
Amended January 1, 2005;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0104 COST REPORTING: AUDITING

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; 42 C.F.R. 447, Subpart C; Eff. January 1, 1978;
Amended Eff. March 22, 1978;
Emergency Amendment [(a), (h)] Eff. April 1, 1978 for a period of 120 days to expire on July 30, 1978;
Emergency Amendment [(a), (h)] Expired Eff. July 30, 1978;
Temporary Amendment Eff. October 1, 1984 for a period of 120 days to expire on January 28, 1985;
Amended Eff. August 1, 1998; June 1, 1995; January 4, 1993; October 1, 1991; December 1, 1988;
Temporary Amendment Eff. August 3, 2004;
Amended Eff. January 1, 2005;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0105 CASE-MIX INDEX CALCULATION

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; S. L. 1985, c. 479, s. 86; 42 C.F.R. 447, Subpart C;
Eff. January 1, 1978;
Amended Eff. March 25, 1980;
Temporary Amendment Eff. October 1, 1984 for a Period of 120 Days to Expire on January 28, 1985;
Amended Eff. March 1, 1994; April 1, 1988; January 28, 1985;
Temporary Amendment Eff. August 3, 2004;
Amended Eff. January 1, 2005;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0106 RECONSIDERATION REVIEWS

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 1985, c. 479, s. 86; 42 C.F.R. 447, Subpart C; Eff. January 1, 1978;
Temporary Amendment Eff. October 1, 1984 for a Period of 120 Days to Expire on January 28, 1985;
Amended Eff. January 4, 1993; November 1, 1991; May 1, 1990; June 1, 1989;
Temporary Amendment Eff. August 3, 2004;
Amended Eff. February 1, 2005;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0107 PAYMENT ASSURANCE

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 1985, c. 479, s. 86; Section 95 of Chapter 689, 1991 Session Laws; 42 C.F.R. 447, Subpart C;
Temporary Rule Eff. October 1, 1984 for a Period of 120 Days to Expire on January 28, 1985;
Eff. January 28, 1985;
Amended Eff. December 1, 1988;
Temporary Amendment Eff. August 1, 1991 For a Period of 180 Days to Expire on January 31, 1992;
Amended Eff. February 1, 1992; October 1, 1991;
Temporary Amendment Eff. August 3, 2004;
Amended Eff. January 1, 2005;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0108 REIMBURSEMENT METHODS FOR STATE-OPERATED FACILITIES

The Division's reimbursement methodology is set forth in the Medicaid State Plan. Any payments in excess of costs shall be refunded to the Division. Any costs in excess of payments shall be paid to the provider.

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 1985, c. 479, s. 86; 42 C.F.R. 447, Subpart C; Eff. January 1, 1992;
Temporary Amendment Eff. August 3, 2004;
Amended Eff. January 1, 2005;
Readopted Eff. July 1, 2018.

10A NCAC 22G .0109 NURSING HOME PROVIDER ASSESSMENT

(a) In accordance with 42 USC 1396b(w) and 42 CFR, Part 433, Subpart B, which are adopted and incorporated by reference with subsequent changes or amendments; and consistent with the CMS Federal Waiver approved April 5, 2004 with an effective date of October 1, 2003, which is adopted and incorporated by reference with subsequent changes or amendments, a monthly nursing facility assessment based on all occupied nursing facility bed days of service shall be imposed on all nursing bed days in licensed nursing facilities, except:

- (1) any nursing facility bed day of service provided by a Continuing Care Retirement Community (CCRC), as defined by G.S. 58-64 and licensed by the North Carolina Department of Insurance; or
- (2) any nursing facility bed day of service paid for under the Medicare program established under Title XVIII of the Social Security Act.

A copy of the CMS Federal Waiver may be obtained by contacting the Division of Health Benefits, 2501 Mail Service Center, Raleigh, North Carolina 27699-2501, (919) 855-4000. Copies of 42 USC 1396b(w) and 42 CFR, Part 433, Subpart B are available free of charge at <http://uscode.house.gov/> and <https://www.ecfr.gov/>, respectively.

(b) The assessment is payable monthly and due to the Department of Health and Human Services or designee of the Department within 15 days of the last day of the reporting month. Facilities shall submit payment and an account of all actual patient days during the month. Failure to provide accurate reporting of days, and payment of assessment within 15 days of the last day of the reporting month shall result in a 10 percent reduction in facility rates for Medicaid participating facilities and recoupment.

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 2003-284, Sec. 10.28; CMS Waiver approved

*April 5, 2004; 42 CFR Part 433, Subpart B; 42 USC 1396b(w);
Temporary Adoption Eff. August 3, 2004;
Eff. January 1, 2005;
Readopted Eff. July 1, 2018;
Amended Eff. March 1, 2020.*

10A NCAC 22G .0110 DEFINITIONS

"Public nursing facility", as used in 10A NCAC 22G, means any nursing facility that is:

- (1) Owned or operated by the State or any department or instrumentality of the State or by county, city, hospital district, or hospital authority; or
- (2) Is operated by a nonprofit corporation or association, a majority of whose board of directors or trustees are appointed by the State or any department or instrumentality of the State or by the governing body of a county, city, hospital district, or hospital authority; or
- (3) Is operated by a hospital that is a "public hospital" under G.S. 159-39(a); or
- (4) Is operated by a hospital that has verified its status by certifying State, local, hospital district or authority governmental control on the most recent version of the Form CMS 1514; or
- (5) Is a facility to which the State or any department or instrumentality of the State or a city or a county makes current appropriations (other than appropriations for the cost of medical care to prisoners or indigents).

*History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; 159-39(a);
Temporary Adoption Eff. August 3, 2004;
Eff. January 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015.*

SECTION .0200 – HOSPITAL INPATIENT REIMBURSEMENT PLAN

10A NCAC 22G .0201 REIMBURSEMENT PRINCIPLES

*History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; 42 C.F.R. 447, Subpart C;
Eff. February 1, 1995;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.*

10A NCAC 22G .0202 DRG RATE SETTING METHODOLOGY

*History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; 42 C.F.R. 447, Subpart C;
Eff. March 1, 1995;
Temporary Amendment Eff. January 22, 1998;
Amended Eff. April 1, 1999;
Temporary Amendment Eff. November 9, 2001;
Temporary Amendment Expired August 30, 2002;
Amended Eff. August 1, 2004;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.*

10A NCAC 22G .0203 EXCEPTIONS TO DRG REIMBURSEMENT

*History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55(c); 42 C.F.R. 447, Subpart C; 42 C.F.R. 447.321;
Eff. February 1, 1995;
Temporary Amendment Eff. September 15, 1995, for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Amended Eff. January 1, 1996;
Temporary Amendment Eff. September 25, 1996;
Temporary Amendment Eff. September 30, 1997;
Temporary Amendment Expired July 31, 1998;
Temporary Amendment Eff. September 16, 1998;*

Temporary Amendment Expired June 13, 1999;
Temporary Amendment Eff. September 22, 1999;
Temporary Amendment Expired July 11, 2000;
Temporary Amendment Eff. June 13, 2001; September 21, 2000;
Temporary Amendment Eff. May 15, 2002;
Amended Eff. April 1, 2003;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0204 DISPROPORTIONATE SHARE HOSPITALS (DSH)

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; 42 C.F.R. 447, Subpart C;
Eff. February 1, 1995;
Amended Eff. July 1, 1995;
Temporary Amendment Eff. September 15, 1995, for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Temporary Amendment Eff. September 29, 1995, for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Amended Eff. January 1, 1996;
Temporary Amendment Eff. September 16, 1998; September 30, 1997; April 15, 1997; September 25, 1996;
Temporary Amendment Expired on June 13, 1999;
Temporary Amendment Eff. September 22, 1999;
Temporary Amendment Expired on July 11, 2000;
Temporary Amendment Eff. May 15, 2002; June 1, 2001; December 10, 2001; September 21, 2000;
Amended Eff. August 1, 2004; April 1, 2003;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0205 OUT OF STATE HOSPITALS

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; 42 C.F.R. 447, Subpart C;
Eff. February 1, 1995;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0206 SPECIAL SITUATION

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; 42 C.F.R. 447 Subpart C;
Eff. February 1, 1995;
Temporary Amendment Eff. December 10, 2001;
Temporary Amendment Expired September 29, 2002;
Amended Eff. August 1, 2004;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0207 COST REPORTING AND AUDITS

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; 42 C.F.R. 447, Subpart C;
Eff. February 1, 1995;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0208 ADMINISTRATIVE RECONSIDERATION REVIEWS

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; 42 C.F.R. 447, Subpart C;
Eff. February 1, 1995;
Repealed Eff. July 1, 2018.

10A NCAC 22G .0209 BILLING STANDARDS

10A NCAC 22G .0210 PAYMENT OF MEDICARE PART A DEDUCTIBLES
10A NCAC 22G .0211 PAYMENT ASSURANCES
10A NCAC 22G .0212 PROVIDER PARTICIPATION
10A NCAC 22G .0213 PAYMENT IN FULL

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; 42 C.F.R. 447, Subpart C;
Eff. February 1, 1995;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

SECTION .0300 - ICF-MR PROSPECTIVE RATE PLAN

10A NCAC 22G .0301 PAYMENT FOR SERVS-PROSPECTIVE REIMBURSEMENT PLAN ICF-MR FACILITIES

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 1985, c. 479, s. 86; 42 C.F.R. 447, Subpart C;
Eff. January 1, 1982;
Temporary Amendment Eff. July 8, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Amended Eff. November 1, 1993;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0302 REPORTING REQUIREMENTS

History Note: Temporary Amendment Eff. July 8, 1993, for a period of 180 days or until the permanent rule becomes effective, whichever is sooner.
Authority G.S. 108A-25(b); 108A-54; 108A-55; 42 C.F.R. 447, Subpart C;
Eff. January 1, 1982;
Amended Eff. August 1, 1995; November 1, 1993; May 1, 1990; April 1, 1988;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0303 REQUIREMENTS FOR FINANCIAL RECORDS

History Note: Temporary Amendment Eff. July 8, 1993, for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Temporary Amendment Eff. July 1, 1992 for a period of 180 days to expire on December 31, 1992;
Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 1985, c. 479, s. 86; 42 C.F.R. Part 447, Subpart C;
Eff. January 1, 1982;
Amended Eff. November 1, 1993; January 4, 1993; January 1, 1993; December 1, 1989;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0304 RATE SETTING METHOD FOR NON-STATE FACILITIES

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; 42 C.F.R. Part 447, Subpart C;
Eff. December 1, 1984;
Amended Eff. March 1, 1988; January 1, 1987;
Temporary Amendment Eff. July 8, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Amended Eff. August 1, 1995; November 1, 1993;
Temporary Amendment Eff. September 8, 1999; August 7, 1998;
Amended Eff. March 19, 2001; August 1, 2000;
Temporary Amendment Eff. December 10, 2001;
Temporary Amendment Expired September 29, 2002;
Amended Eff. August 1, 2004;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0305 ALLOWABLE COSTS
10A NCAC 22G .0306 PAYMENT ASSURANCE
10A NCAC 22G .0307 REIMBURSEMENT METHODS FOR STATE-OPERATED FACILITIES
10A NCAC 22G .0308 RATE APPEALS
10A NCAC 22G .0309 AUDITS

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 1985, c. 479, s. 86; 42 C.F.R. 447, Subpart C; Temporary Adoption Eff. July 8, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner; Eff. November 1, 1993; Amended Eff. August 1, 1995; Temporary Amendment Eff. June 26, 2003; Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

SECTION .0400 - PROVIDER FEE SCHEDULES

10A NCAC 22G .0401 PHYSICIAN'S FEE SCHEDULE

History Note: Authority G.S. 108A-25(b); Eff. October 1, 1982; Amended Eff. July 1, 1997; July 1, 1995; January 4, 1993; June 1, 1990; December 1, 1988; Temporary Amendment Eff. July 22, 1998; January 22, 1998; Amended Eff. April 1, 1999; Temporary Amendment Eff. January 1, 2000 (This temporary amendment amends and replaces a permanent rulemaking originally proposed to be effective August 2000); Amended Eff. March 19, 2001; Temporary Amendment Eff. September 10, 2001; Temporary Amendment Expired June 28, 2002; Amended Eff. April 1, 2003; Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0402 OTHER SERVICES PERFORMED BY PHYSICIANS AND OTHER PRACTITIONERS

History Note: Authority G.S. 108A-25(b); S.L. 1985, c. 479, s. 86; Eff. January 4, 1993; Temporary Amendment Eff. March 7, 2002; Temporary Amendment Expired December 27, 2002; Amended Eff. August 1, 2004; Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A;

SECTION .0500 – REIMBURSEMENT FOR SERVICES

10A NCAC 22G .0501 CLINIC SERVICES

History Note: Authority G.S. 108A-25(b); S.L. 1985, c. 479, s. 86; Eff. February 1, 1984; Temporary Amendment Eff. November 9, 2001; Temporary Amendment Expired August 30, 2002; Amended Eff. April 1, 2003; Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0502 MENTAL HEALTH CLINIC SERVICES

History Note: Authority G.S. 108A-25(b); S.L. 1985, c. 479, s. 86;

Eff. February 1, 1984;
Repealed Eff. July 1, 2018.

10A NCAC 22G .0503 INPATIENT HOSPITAL: INAPPROPRIATE LEVEL OF CARE

History Note: Authority G.S. 108A-25(b); 42 C.F.R. 447.253; S.L. 1985, c. 479, s. 86;
Eff. May 1, 1984;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0504 HEALTH MAINTENANCE ORGANIZATIONS AND PREPAID HEALTH PLANS

Reimbursement to Health Maintenance Organizations and Prepaid Health Plans for services rendered shall be paid as a monthly capitation fee developed by the Division and set out in contract with the Health Maintenance Organization or Prepaid Health Plan.

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 1985, c. 479, s. 86; 42 C.F.R. Part 434; 42 C.F.R. Part 438.6;
Eff. August 1, 1984;
Amended Eff. February 1, 1985;
Readopted Eff. July 1, 2018.

10A NCAC 22G .0505 PERSONAL CARE SERVICES

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; 131D-4.1; 131D-4.2; S.L. 1995 c. 507, s. 23.10;
42 C.F.R. 440.170(f);
Eff. January 1, 1986;
Temporary Amendment Eff. April 22, 1996; January 9, 1997;
Amended Eff. August 1, 1998;
Temporary Amendment Eff. January 1, 2000;
Temporary Amendment Expired on October 28, 2000;
Temporary Amendment Eff. July 1, 2002;
Amended Eff. August 1, 2002;
Temporary Amendment Eff. January 13, 2003;
Amended Eff. August 1, 2004;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0506 INDEPENDENT LABORATORY SERVICES

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; P.L. 93-369; P.L. 99-272; 42 C.F.R. 447.10; 42 C.F.R. 447.342;
Eff. March 1, 1987;
Amended Eff. September 1, 1991;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0507 DURABLE MEDICAL EQUIPMENT AND RELATED SUPPLIES

History Note: Authority G.S. 108A-25(b); 42 C.F.R. 447, Subpart D; 1991 S.L, s. 95, c. 689;
Eff. March 1, 1990;
Temporary Amendment Eff. August 1, 1991 for a period of 180 days to expire on January 31, 1992;
Amended Eff. December 1, 1995; February 1, 1992;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0508 PRIVATE DUTY NURSING

History Note: Authority G.S. 108A-25(b); 108A-54; 42 C.F.R. 440.80;

Eff. January 1, 1994;
Temporary Amendment Eff. December 20, 2002; July 1, 2002;
Temporary Amendment Expired November 28, 2003;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

**10A NCAC 22G .0509 REIMBURSEMENT PRINCIPLES, HEARING
AIDS/ACCESSORIES/BATTERIES**

History Note: Authority G.S. 108A-25(b); 108A-54;
Eff. January 4, 1993;
Recodified from 10 NCAC 26H .0509 Eff. January 1, 1994;
Repealed Eff. July 1, 2018.

10A NCAC 22G .0510 CASE MANAGEMENT SERVICES

History Note: Authority G.S. 108A-25(b); 108A-54; 1915 (g) of the Social Security Act;
Eff. April 1, 1994;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

SECTION .0600 - HOME HEALTH PROSPECTIVE REIMBURSEMENT

10A NCAC 22G .0601 REIMBURSEMENT PRINCIPLES

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 1985, c. 479, s. 86; 42 C.F.R. 440.70;
Eff. October 1, 1987;
Amended Eff. October 1, 1992;
Temporary Amendment Eff. August 1, 1991 for a period of 180 days to expire on
January 31, 1992;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0602 REIMBURSEMENT METHODS

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 1985, c.479, s. 86; 42 C.F.R. 440.70;
Eff. October 1, 1987;
Amended Eff. October 1, 1992; May 1, 1990;
Temporary Amendment Eff. October 4, 1996;
Amended Eff. April 1, 1997;
Temporary Amendment Eff. July 25, 1997;
Amended Eff. August 1, 1998;
Temporary Amendment Eff. November 9, 2001;
Temporary Amendment Expired August 30, 2002;
Amended Eff. April 1, 2003;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0603 APPEALS

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 1985. c. 479, s. 86; 42 C.F.R. 440.70;
Eff. October 1, 1987;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0604 COST REPORTING AND AUDITING

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 1985, c. 479, s. 86; 42 C.F.R. 440.70;
Eff. October 1, 1987;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22G .0605 PAYMENT ASSURANCES

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-55; S. L. 1985, c. 479, s. 86; 42 C.F.R. 440.70; Eff. October 1, 1987;
Amended Eff. October 1, 1992; May 1, 1990;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

SUBCHAPTER 22H - APPEALS PROCEDURES

SECTION .0100 - BENEFICIARY APPEALS FOR DENIAL, TERMINATION, SUSPENSION, OR REDUCTION OF A MEDICAID SERVICE OR AN AUTHORIZATION FOR A MEDICAID SERVICE

10A NCAC 22H .0101 APPEALS BY MEDICAID BENEFICIARIES

Appeals by Medicaid beneficiaries of determinations by the Division to deny, terminate, suspend, or reduce a Medicaid service or an authorization for a Medicaid service are governed by G.S. 108A-70.9A and G.S. 108A-70.9B.

History Note: Authority G.S. 108A-25(b); 108A-70.9A; 108A-70.9B; 42 C.F.R. 431; 42 C.F.R. 456; Eff. April 13, 1979;
Amended Eff. May 1, 1990; November 1, 1983; October 4, 1979;
RRC objection due to lack of Authority and ambiguity Eff. October 18, 1995;
Amended Eff. December 11, 1995;
Readopted Eff. July 1, 2018.

10A NCAC 22H .0102 REQUESTS FOR FORMAL AND INFORMAL APPEALS

10A NCAC 22H .0103 TIME LIMITS ON REQUESTS FOR RECIPIENT/APPLICANT INFORMAL APPEALS

History Note: Authority G.S. 108A-25(b); 42 C.F.R. 431; 42 C.F.R. 456; Eff. April 13, 1979;
Amended Eff. December 1, 1995; May 1, 1990; November 1, 1983; October 4, 1979;
RRC objection to Rule .0103 due to lack of Authority and ambiguity Eff. October 18, 1995;
Amended Eff. December 11, 1995;
Repealed Eff. July 1, 2018.

10A NCAC 22H .0104 PAYMENT PENDING APPEALS

If a final decision rendered in accordance with G.S. 108A-70.9B(g) upholds the adverse determination, as defined in G.S. 108A-70.9A(a), the Division may institute recovery procedures against the beneficiary to recoup the cost of any services furnished resulting from the appeal process.

History Note: Authority G.S. 108A-25(b); 108A-70.9A; 108A-70.9B; 42 C.F.R. 431.230(b); Eff. April 13, 1979;
Amended Eff. December 1, 1995; October 4, 1979;
Readopted Eff. July 1, 2018.

10A NCAC 22H .0105 DISMISSAL OF APPEAL

History Note: Authority G.S. 108A-25(b); 42 C.F.R. Part 431; Eff. April 13, 1979;
Amended Eff. December 1, 1995; May 1, 1990;
Repealed Eff. July 1, 2018.

SECTION .0200 - HEARINGS: TRANSFER AND DISCHARGES FROM NURSING FACILITIES

10A NCAC 22H .0201 DEFINITIONS

The following definitions shall apply throughout this Section:

- (1) "Division" means the North Carolina Division of Health Benefits, Department of Health and Human Services.
- (2) "Hearing Officer" means the person designated by the Chief Hearing Officer of the Division's Hearing Unit to preside over hearings between a resident and a nursing facility provider regarding transfers and discharges.
- (3) "Hearing Unit" means the Chief Hearing Officer and his or her staff in the Division of Health Benefits, Department of Health and Human Services.
- (4) "Notice of Transfer or Discharge form" means the form developed by the Division containing the elements described at 42 C.F.R. 483.15(c)(5), which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at <https://www.ecfr.gov/>.
- (5) "Request for Hearing" means a written request by the resident, family member, or legal representative of the resident that the resident wants to appeal the facility's decision to transfer or discharge.
- (6) The "Nursing Home Hearing Request Form " means the form developed by the Division containing:
 - (a) the resident's name;
 - (b) the facility's name;
 - (c) the date of the Notice of Transfer or Discharge form;
 - (d) the date of the scheduled transfer or discharge;
 - (e) the requestor's preference for a telephone hearing or in-person hearing in Raleigh, North Carolina;
 - (f) the requestor's name, address, telephone number, and signature; and
 - (g) the telephone number, fax number, mailing address, and email address of the Division's Hearing Unit.

History Note: Authority G.S. 108A-25(b); 42 USCS 1396r(e)(3), (f)(3); 42 C.F.R. Part 483; Eff. April 1, 1994; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015; Amended Eff. July 1, 2018; Amended Eff. March 1, 2020.

10A NCAC 22H .0202 TRANSFER AND DISCHARGE REQUIREMENTS

- (a) To transfer or discharge a resident, a facility shall comply with all of the requirements of 42 C.F.R. 483.15, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at <https://www.ecfr.gov/>.
- (b) In addition to the requirements in Paragraph (a) of this Rule, a resident and, if contact information is available, a family member or legal representative of the resident, shall be notified in writing of a facility's decision to transfer or discharge the resident. The Notice of Transfer or Discharge form shall be used by a facility when giving notice of a transfer or discharge.
- (c) Failure to complete the Notice of Transfer or Discharge form shall result in the notice of the transfer or discharge being invalid.
- (d) The resident shall be handed the Notice of Transfer or Discharge form on the same day that it is dated.
- (e) A copy of the notice of Transfer or Discharge form shall be mailed to the family member or legal representative, if contact information is available, on the same day that it is dated.
- (f) The facility shall provide a Nursing Home Hearing Request Form to the resident and to the family member or legal representative, if contact information is available, at the same time as providing the Notice of Transfer or Discharge form.

History Note: Authority G.S. 108A-25(b); 150B-21.6; 42 USCS 1396r(e)(3), (f)(3); 42 C.F.R. 483; Eff. April 1, 1994; Readopted Eff. July 1, 2018.

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, family member, or legal representative shall submit a written request for a hearing to the Hearing Unit. The request for hearing shall 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, 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, or legal holiday.
- (b) The request for hearing shall be submitted to the Hearing Unit by mail, 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; Eff. April 1, 1994; Readopted Eff. July 1, 2018.

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 as set out in Rule .0203 of this Section, the Hearing Unit shall notify the parties of the request.
- (b) The parties shall be notified by certified mail of the date, 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 facility 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. The facility administrator shall forward identical information to the Hearing Unit, to be received at least five business days prior to the hearing.
- (d) The hearing officer may grant continuances for good cause. For purposes of this Rule, circumstances beyond the control of the party constitute good cause.
- (e) The hearing officer shall 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.
- (f) The hearing officer shall 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. 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; Eff. April 1, 1994; Readopted Eff. July 1, 2018.

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. 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. 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; Eff. April 1, 1994; Readopted Eff. July 1, 2018.

SECTION .0300 - PASRR HEARINGS

10A NCAC 22H .0301 DEFINITIONS

The following definitions shall apply throughout this Section:

- (1) "Division" means the North Carolina Division of Health Benefits, Department of Health and Human Services.

- (2) "Hearing Officer" means the person designated by the Chief Hearing Officer of the Division's Hearing Unit to preside over hearings regarding Preadmission Screening and Resident Review (PASRR) determinations.
- (3) "Hearing Unit" means the Chief Hearing Officer and his or her staff in the Division of Health Benefits, Department of Health and Human Services.
- (4) "Preadmission Screening and Resident Review (PASRR) Notice of Determination" means the form developed by the Division, containing the elements described at 42 C.F.R. 483.130(k), which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at <https://www.ecfr.gov/>.
- (5) "Request for Hearing" means a written request on a Hearing Request Form by the evaluated individual or family member or legal representative of the evaluated individual, that the evaluated individual wants to appeal the (PASRR) determination.
- (6) The "Hearing Request Form" means the form developed by the Division containing:
 - (a) the individual's name;
 - (b) the facility name, if the individual is residing in a facility;
 - (c) the requestor's preference for a telephone hearing or in-person hearing in Raleigh, North Carolina; and
 - (d) the requestor's name, address, telephone number, and signature.
- (7) The "North Carolina PASRR II Screening Form" means both the North Carolina PASRR-MI Psychiatric Screening form and the North Carolina Dual Psychiatric and Intellectual Developmental Disabilities/Related Conditions PASRR II Screening Data form developed by the Division, containing the elements described at 42 C.F.R. 483.128(i)–(j), 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); 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. 483.128; 42 C.F.R. 483.130; Eff. October 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;
Amended Eff. July 1, 2018;
Amended Eff. March 1, 2020.

10A NCAC 22H .0302 PASRR REQUIREMENTS

- (a) The evaluated individual and family member or legal representative shall be notified in writing of the Division of MH/DD/SAS' PASRR determination under the provisions of 42 CFR 483.130 which is incorporated by reference with subsequent changes or amendments and available free of charge at <https://www.ecfr.gov/>.
- (b) The PASRR Notice of Determination form shall be used by Division of MH/DD/SAS when giving notice of a PASRR determination.
- (c) The Division of MH/DD/SAS shall provide a Hearing Request form, PASRR II Screening form, and PASRR 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/>.

History Note: Authority G.S. 108A-25(b); 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; Eff. October 1, 1994;
Readopted Eff. July 1, 2018.

10A NCAC 22H .0303 INITIATING A HEARING

- (a) In order to initiate an appeal of a PASRR determination, the evaluated individual, family member, or legal representative shall submit a Hearing Request Form to the Hearing Unit. The form shall be received by the Hearing Unit within 11 calendar days from the date of the PASRR Notice of Determination. If the 11th day falls on a Saturday, 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, or legal holiday.
- (b) The Hearing Request Form shall be submitted to the Hearing Unit by mail, facsimile, or hand delivery.

History Note: Authority G.S. 108A-25(b); 42 U.S.C.S. 1395i - 3(e)(3) and - (f)(3); 1396r(e)(3), (e)(7)(F), and (f)(3); 42 C.F.R. 431.200; 42 C.F.R. 483.5; 42 C.F.R. Part 483, Subpart E; Eff. October 1, 1994; Readopted Eff. July 1, 2018.

10A NCAC 22H .0304 HEARING PROCEDURES

- (a) Upon receipt of a Hearing Request Form to appeal a PASRR determination, 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, 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 days prior to the hearing.
- (d) The hearing officer may grant continuances for good cause. For purposes of this Rule, circumstances beyond the control of the party constitute good cause.
- (e) The hearing officer shall 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.
- (f) The hearing officer shall 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. 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 U.S.C.S. 1395i-3(e)(3), (f)(3); 42 C.F.R. 431, Subpart E; 42 C.F.R. Part 483, Subpart E; Eff. October 1, 1994; Readopted Eff. July 1, 2018.

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. The Division 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), (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; Eff. October 1, 1994; Readopted Eff. July 1, 2018.

SUBCHAPTER 22I - TITLE XIX REIMBURSEMENT AND ADMINISTRATIVE REVIEW PROCESS

SECTION .0100 - AUDIT REVIEW PROCESS

10A NCAC 22I .0101 AUDIT TO BE CONDUCTED

An audit of a provider may be conducted by the Division of Health Benefits, or by an auditing firm subcontracted by them.

History Note: Authority G.S. 108A-25(b); Eff. September 24, 1980;

Amended Eff. May 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;
Amended Eff. March 1, 2020.

10A NCAC 22I .0102 EXIT CONFERENCE

At the conclusion of the audit, the provider may request an exit conference to discuss the audit findings with the provider that shall be held by personnel of the unit conducting the audit.

History Note: Authority G.S. 108A-25(b);
Eff. September 24, 1980;
Readopted Eff. July 1, 2018.

10A NCAC 22I .0103 NOTICE OF PROGRAM REIMBURSEMENT

Based on the audit findings the Division of Health Benefits will issue to the provider a Notice of Program Reimbursement which shall state the amount of reimbursement, if any, payable to the Division of Health Benefits or payable to the provider.

History Note: Authority G.S. 108A-25(b);
Eff. September 24, 1980;
Amended Eff. January 1, 1988;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;
Amended Eff. March 1, 2020.

10A NCAC 22I .0104 RECONSIDERATION REVIEW

History Note: Authority G.S. 108A-25(b);
Eff. September 24, 1980;
Amended Eff. January 1, 1988;
Repealed Eff. July 1, 2018.

SUBCHAPTER 22J - TITLE XIX APPEALS PROCEDURES

10A NCAC 22J .0101 PURPOSE AND SCOPE

The purpose of these regulations is to specify the rights of providers to appeal reimbursement rates, payment denials, disallowances, payment adjustments and cost settlement disallowances and adjustments. Provider appeals for program integrity action are specified in 10A NCAC 22F.

History Note: Authority G.S. 108A-25(b); 108A-54; 150B-11; 42 U.S.C. 1396(b);
Eff. January 1, 1988;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015.

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, and adjustments. 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 mean that all administrative actions necessary to have a claim paid have been taken by the provider and the Division 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 action shall become final.

(b) A request for reconsideration review shall be in writing and signed by the provider or the provider's representative and contain the provider's name, address, and telephone number. It shall state the specific

dissatisfaction with the Division's action and should be mailed to: Appeals, Division of Health Benefits, 2501 Mail Service Center, Raleigh, North Carolina 27699-2501.

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

History Note: Authority G.S. 108A-25(b); 108A-54; 42 U.S.C. 1396b; 42 C.F.R. 455.512;
Eff. January 1, 1988;
Readopted Eff. July 1, 2018;
Amended Eff. March 1, 2020.

10A NCAC 22J .0103 RECONSIDERATION REVIEW PROCESS

(a) Upon receipt of a request for a reconsideration review that is submitted timely pursuant to Rule .0102 of this Subchapter, the Deputy Director shall appoint a reviewer or panel to conduct the review. The Division shall arrange with the provider a time and date of the hearing. The provider shall reduce his arguments to writing and submit them to the Division 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. For purposes of this Rule, "good cause" is an action outside the control of the provider.

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

(c) Following the review, the Division 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; 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)*;
Readopted Eff. July 1, 2018.

10A NCAC 22J .0104 PETITION FOR A CONTESTED CASE HEARING

If the provider disagrees with the reconsideration review decision, the provider may request a contested case hearing in accordance with G.S. 150B, Article 3 and 26 NCAC 03 .0103.

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

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;
Repealed Eff. September 1, 2018.

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 a patient as a Medicaid patient 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. 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;
- (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;
- (2) before the service or supply is 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 as specified in the Medicaid State Plan or applicable clinical coverage policy promulgated pursuant to G.S. 108A-54.2(b);
- (3) the patient is 65 years of age or older and is enrolled in the Medicare program at the time services or supplies are received but has failed to supply a Medicare number as proof of coverage; or
- (4) the patient is not eligible for Medicaid as defined in the Medicaid State Plan.

(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;
- (2) the Division 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, plus any authorized deductible, co-insurance, co-payment, and third party payment as payment in full for all Medicaid covered services or supplies provided, except that a provider shall not deny services or supplies to any Medicaid patient on account of the individual's inability to pay a deductible, co-insurance, or co-payment amount as specified in the Medicaid State Plan. 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 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.

History Note: Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 108A-54.2; 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; Readopted Eff. March 21, 2019.

SUBCHAPTER 22K - QUALIFIED PROVIDERS

10A NCAC 22K .0101 DEFINITION

A provider qualified to make presumptive determinations of Medicaid eligibility for pregnant women shall meet the conditions required by Section 1920 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 sign a written agreement with the Division of Health Benefits (Division).

History Note: Authority G.S. 108A-25(b); 42 U.S.C. 1396r-1; 42 C.F.R. 435.1103; Eff. June 1, 1998; Readopted Eff. July 1, 2018; Amended Eff. March 1, 2020.

10A NCAC 22K .0102 AGREEMENT

(a) The provider shall participate in training offered by the Division or its agents and make presumptive eligibility determinations in accordance with 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.

(b) The Division 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 within five business days or fails to follow procedures set forth in the Medicaid State Plan, resulting in eligibility denials for a majority of the provider's referrals.

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

History Note: Authority G.S. 108A-25(b); 42 U.S.C. 1396r-1; 42 C.F.R. 435.1103;
Eff. June 1, 1988;
Readopted Eff. July 1, 2018.

10A NCAC 22K .0103 PRESUMPTIVE DETERMINATIONS

(a) Presumptive determinations of eligibility shall apply only to pregnant women whose family income does not exceed the federal poverty guidelines issued in the Federal Register by the US Department of Health and Human Services and revised annually, which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at <https://aspe.hhs.gov/poverty-guidelines>.

(b) Only one presumptive determination of eligibility during a single pregnancy shall be made by the same qualified provider.

(c) A presumptive determination of eligibility may be made by a different qualified provider if the provider has no knowledge of a prior determination.

History Note: Authority G.S. 108A-25(b); 42 U.S.C. 1396r-1; 42 CFR 435.1103;
Eff. June 1, 1988;
Readopted Eff. July 1, 2018.

SUBCHAPTER 22L - MANAGED CARE AND PREPAID PLANS

SECTION .0100 - MANAGED CARE

10A NCAC 22L .0101 PROGRAM DEFINITION

The Division's primary care case management contractor shall contract with primary care physicians in participating counties to deliver and coordinate the health care of certain categories of Medicaid beneficiaries listed in 10A NCAC 22L .0104.

History Note: Authority G.S. 108A-25(b);
Eff. August 3, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;
Amended Eff. July 1, 2018.

10A NCAC 22L .0102 COORDINATION FEE

In addition to normal Medicaid payments, the Division may pay participating physicians a monthly fee to provide case management 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);
Eff. August 3, 1992.
Readopted Eff. July 1, 2018.

10A NCAC 22L .0103 ACCESS TO CARE

The Division's primary care case management enrollees shall be eligible to receive health care services that Medicaid beneficiaries are eligible for. Beneficiaries receive services through their primary care physician who either provides or coordinates health care.

History Note: Authority G.S. 108A-25(b);
Eff. August 3, 1992;
Readopted July 1, 2018.

10A NCAC 22L .0104 ENROLLMENT

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

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

- (1) Medicaid for Pregnant Women;
- (2) benefit diversion beneficiaries;
- (3) beneficiaries with end stage renal disease; and
- (4) Native Americans/Alaska Natives.

History Note: Authority G.S. 108A-25(b);
Eff. August 3, 1992;
Readopted Eff. July 1, 2018.

10A NCAC 22L .0105 EMERGENCY ROOM CARE

History Note: Authority G.S. 108A-25(b); Section 93(h) of Chapter 689, 1991 North Carolina Session laws;
Eff. August 3, 1992;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

SECTION .0200 - PREPAID PLANS

10A NCAC 22L .0201 PROGRAM DEFINITION

History Note: Authority G.S. 108A-25(b);
Eff. August 3, 1992;
Amended Eff. April 1, 1999;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;
Repealed Eff. July 1, 2018.

10A NCAC 22L .0202 ENROLLMENT

History Note: Authority G.S. 108A-25(b);
Eff. August 3, 1992;
Amended Eff. April 1, 1999;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22L .0203 ACCESS TO CARE

History Note: Authority G.S. 108A-25(b); 42 U.S.C. 1396u-2(b)(2)(B),(C);
Eff. August 3, 1992;
Amended Eff. April 1, 1999;
Repealed Eff. July 1, 2018.

SUBCHAPTER 22M - DRUG USE REVIEW (DUR)

SECTION .0100 - DRUG USE REVIEW BOARD

10A NCAC 22M .0101 ESTABLISHMENT (TRANSFERRED TO 10A NCAC 25K .0301)
10A NCAC 22M .0102 MEMBERSHIPS (TRANSFERRED TO 10A NCAC 25K .0302)

10A NCAC 22M .0103 CHAIRMEN (TRANSFERRED TO 10A NCAC 25K .0303)

10A NCAC 22M .0104 ACTIVITIES (TRANSFERRED TO 10A NCAC 25K .0304)

SECTION .0200 - PROSPECTIVE DRUG REVIEW

10A NCAC 22M .0201 PATIENT COUNSELING (TRANSFERRED TO 10A NCAC 25K .0401)

SECTION .0300 - RETROSPECTIVE DRUG USE REVIEW

10A NCAC 22M .0301 RETROSPECTIVE DRUG USE REVIEW (DUR) (TRANSFERRED TO 10A NCAC 25K .0501)

10A NCAC 22M .0302 SCREENING AND PATTERN ANALYSIS (TRANSFERRED TO 10A NCAC 25K .0502)

10A NCAC 22M .0303 INTERVENTIONS (TRANSFERRED TO 10A NCAC 25K .0503)

10A NCAC 22M .0304 COMPLIANCE MONITORING (TRANSFERRED TO 10A NCAC 25K .0504)

SUBCHAPTER 22N – PROVIDER ENROLLMENT

SECTION .0100 – GENERAL

10A NCAC 22N .0101 DEFINITIONS

- (a) For the purpose of this Subchapter, a "provider" is defined as in G.S. 108C-2(10).
- (b) For the purpose of this Subchapter, an "owner" is defined as in G.S. 108C-2(9).

History Note: Authority G.S. 108A-54; 108C-2(9),(10); 143B-139.1; 42 C.F.R. 400.203; 42 C.F.R. 455.101; Eff. July 1, 2004; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015; Amended Eff. July 1, 2018.

10A NCAC 22N .0102 SIGNED AGREEMENTS

Each provider shall sign a Provider Administrative Participation Agreement with the Department and shall not be reimbursed for services rendered prior to the effective date of the participation agreement.

History Note: Authority G.S. 108A-54; 143B-139.1; 42 C.F.R. Part 455, Subpart E; Eff. July 1, 2004; Readopted Eff. July 1, 2018.

SECTION .0200 - ENTITIES LICENSED UNDER NCGS 122C OR NCGS 131D

10A NCAC 22N .0201 DEFINITIONS

History Note: Authority G.S. 108A-54; 143B-139.1;

Eff. July 1, 2004;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;

Repealed Eff. July 1, 2018.

10A NCAC 22N .0202 DISCLOSURE OF OWNERSHIP

Providers who undergo a change in ownership as defined in G.S. 108C-10 shall comply with the following disclosure conditions:

- (1) when applying to participate in the North Carolina Medicaid program, the provider shall supply the legal name and social security number of each individual who is an owner;
- (2) an enrolled provider shall notify the Division in writing of a change in the legal name of any owner. The notification shall be received within 30 calendar days of the effective date of any change;
- (3) an enrolled provider shall notify the Division in writing if a new owner joins the provider. The notification shall include the new owner's legal name and social security number. The notification shall be received within 30 calendar days of the effective date of any change; and
- (4) an enrolled provider shall notify the Division in writing if an owner withdraws his ownership interest in the provider. The notification shall include the name of the departing owner and shall be received within 30 calendar days of the effective date of any change.

History Note: Authority G.S. 108A-54; 108C-10; 143B-139.1; 42 C.F.R. 455.104; 42 C.F.R. 455.106; Eff. July 1, 2004; Readopted Eff. July 1, 2018.

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).

(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 that was previously held by the applicant and the applicant voluntarily relinquished the license;
- (2) there is a pending appeal of a denial, 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 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 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 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 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 provider shall not provide the new service until a decision is made to enroll the provider, despite an appeal action.

(d) If the denial is reversed on appeal, the 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/>.

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

SECTION .0300 – ENTITIES PROVIDING SPECIFIED HABILITATIVE AND REHABILITATIVE SERVICES

10A NCAC 22N .0301 DEFINITIONS

History Note: Authority G.S. 108A-54; 143B-139.1;
 Eff. July 1, 2004;
 Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;
 Repealed Eff. July 1, 2018.

10A NCAC 22N .0302 DISCLOSURE OF OWNERSHIP
10A NCAC 22N .0303 ENROLLMENT RESTRICTIONS

History Note: Authority G.S. 108A-54; 143B-139.1;
 Eff. July 1, 2004;
 Repealed Eff. July 1, 2018.

SUBCHAPTER 220 - MEDICAL ASSISTANCE PROVIDED

SECTION .0100 - GENERAL

10A NCAC 220 .0101 HOSPITAL INPATIENT

History Note: Authority G.S. 108A-25(b); 108A-54; 42 C.F.R. 440.10;
 Eff. February 1, 1976;
 Readopted Eff. October 31, 1977;
 Amended Eff. January 1, 1984;
 Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 220 .0102 HOSPITAL OUTPATIENT (TRANSFERRED TO 10A NCAC 25M .0301)

10A NCAC 220 .0103 HOME HEALTH SERVICES (TRANSFERRED TO 10A NCAC 25O .0201(A))

10A NCAC 220 .0104 LABORATORY AND X-RAY SERVICES (ITEMS (1)-(3) TRANSFERRED TO 10A NCAC 25P .0406 AND ITEMS (4)-(5) TRANSFERRED TO 10A NCAC 25U .0201))

10A NCAC 220 .0105 EYEGLASSES AND OPTOMETRIC SERVICES (TRANSFERRED TO 10A NCAC 25N .0301)

10A NCAC 220 .0106 CHIROPRACTIC SERVICES (TRANSFERRED TO 10A NCAC 25P .0403)

10A NCAC 220 .0107 MENTAL HEALTH CENTER SERVICES (TRANSFERRED TO 10A NCAC 25C .0201)

10A NCAC 220 .0108 INTERMEDIATE CARE FACILITIES (TRANSFERRED TO 10A NCAC 25D .0201(a)-(b))

10A NCAC 220 .0109 HEARING AID SERVICES (TRANSFERRED TO 10A NCAC 25N .0201)

10A NCAC 220 .0110 AMBULANCE SERVICES (TRANSFERRED TO 10A NCAC 25W .0201)

10A NCAC 220 .0111 INPATIENT PSYCHIATRIC HOSPITAL SERVICES (TRANSFERRED TO 10A NCAC 25C .0301)

10A NCAC 220 .0112 PSYCHIATRIC ADMISSION CRITERIA/MEDICAID BENEFICIARIES UNDER AGE 21

History Note: Authority G.S. 108A-25(b); 108A-54; 42 C.F.R. 441, Subpart D; 42 C.F.R. 441.151; Eff. October 1, 1993; Amended Eff. February 1, 1996; Repealed Eff. July 1, 2018.

10A NCAC 220 .0113 NC MEDICAID CRITERIA FOR CONTINUED ACUTE STAY IN AN INPATIENT PSYCHIATRIC FACILITY (TRANSFERRED TO 10A NCAC 25C .0302)

10A NCAC 220 .0114 NORTH CAROLINA SPECIALTY HOSPITAL SERVICES (TRANSFERRED TO 25M .0201(e))

10A NCAC 220 .0115 CLINIC SERVICES (TRANSFERRED TO 10A NCAC 25P .0402)

10A NCAC 220 .0116 SKILLED NURSING FACILITY (TRANSFERRED TO 10A NCAC 25M .0401(a)-(c))

10A NCAC 220 .0117 ABORTION (TRANSFERRED TO 10A NCAC 25P .0405)

10A NCAC 220 .0118 PHARMACY SERVICES (TRANSFERRED TO 10A NCAC 25K .0201)

10A NCAC 220 .0119 OUT-OF-STATE SERVICES (TRANSFERRED TO 10A NCAC 25S .0201)

10A NCAC 220 .0120 PERSONAL CARE SERVICES (TRANSFERRED TO 10A NCAC 25O .0202(a)-(b))

10A NCAC 220 .0121 DURABLE MEDICAL EQUIPMENT

History Note: Authority G.S. 108A-25(b); 42 C.F.R. 440.70(b)(3); Eff. March 1, 1990; Amended Eff. March 1, 1993; Recodified from 10 NCAC 26B .0120 Eff. October 1, 1993; Recodified from 10 NCAC 26B .0121 Eff. January 1, 1998; Repealed Eff. September 1, 2005.

10A NCAC 220 .0122 PRIVATE DUTY NURSING (TRANSFERRED TO 10A NCAC 25O .0204)

10A NCAC 220 .0123 CASE MGMT SVCS/ADULTS/CHILDREN AT-RISK/ABUSE/NEGLECT/EXPOITATION (TRANSFERRED TO 10A NCAC 25F .0201)

10A NCAC 220 .0124 HIV CASE MANAGEMENT (TRANSFERRED TO 10A NCAC 25F .0301)

10A NCAC 220 .0125 HOME INFUSION THERAPY (TRANSFERRED TO 10A NCAC 25O .0203)

SECTION .0200 - DENTAL SERVICES

10A NCAC 220 .0201 DEFINITIONS (TRANSFERRED TO 10A NCAC 25H .0201)

- 10A NCAC 220 .0202 STANDARDS FOR PARTICIPATION (TRANSFERRED TO 10A NCAC 25H .0203)**
- 10A NCAC 220 .0203 ELIGIBILITY (TRANSFERRED TO 10A NCAC 25H .0202)**
- 10A NCAC 220 .0204 AMOUNT; DURATION; AND SCOPE OF SERVICES (TRANSFERRED TO 10A NCAC 25H .0204)**
- 10A NCAC 220 .0205 RESTRICTIONS AND PRIOR APPROVAL (TRANSFERRED TO 10A NCAC 25H .0205)**
- 10A NCAC 220 .0206 GUIDELINES ON SERVICES (TRANSFERRED TO 10A NCAC 25H .0301)**
- 10A NCAC 220 .0207 SPECIFIC GUIDELINES (TRANSFERRED TO 10A NCAC 25H .0302)**
- 10A NCAC 220 .0208 ANESTHESIA (TRANSFERRED TO 10A NCAC 25H .0303)**
- 10A NCAC 220 .0209 ANALGESIA (TRANSFERRED TO 10A NCAC 25H .0304)**
- 10A NCAC 220 .0210 DRUGS (TRANSFERRED TO 10A NCAC 25H .0305)**
- 10A NCAC 220 .0211 PRIOR APPROVAL (TRANSFERRED TO 10A NCAC 25H .0206)**

SECTION .0300 – AMOUNT, DURATION, AND SCOPE OF ASSISTANCE

- 10A NCAC 220 .0301 MEDICAL SERVICES (TRANSFERRED TO 10A NCAC 25A .0201)**

SECTION .0400 – LIMITATION OF AMOUNT, DURATION, AND SCOPE OF ASSISTANCE

- 10A NCAC 220 .0401 INPATIENT HOSPITAL SERVICES (PARAGRAPHS (a)-(d) TRANSFERRED TO 10A NCAC 25M .0201 AND PARAGRAPH (e) TRANSFERRED TO 10A NCAC 25P .0201))**
- 10A NCAC 220 .0402 OUTPATIENT HOSPITAL SERVICES (TRANSFERRED TO 10A NCAC 25P .0301)**
- 10A NCAC 220 .0403 SKILLED NURSING FACILITY SERVICES (TRANSFERRED TO 10A NCAC 25M .0401(d))**
- 10A NCAC 220 .0404 PHYSICIAN SERVICES (TRANSFERRED TO 10A NCAC 25P .0401)**
- 10A NCAC 220 .0405 PODIATRIST SERVICES (TRANSFERRED TO 10A NCAC 25P .0404)**
- 10A NCAC 220 .0406 HOME HEALTH SERVICES (TRANSFERRED TO 10A NCAC 25O .0201(b)-(e))**
- 10A NCAC 220 .0407 PRESCRIBED DRUGS**

History Note: Authority G.S. 108A-25(b); 143B-10; S.L. 1985, c. 479, s. 86; 42 C.F.R. 440.120; 42 C.F.R. 440.230(d)
 Eff. February 1, 1976
 Amended Eff. October 1, 1977;
 Readopted Eff. October 31, 1977
 Amended Eff. May 1, 1990; August 1, 1983; April 1, 1982;
 Repealed Eff. April 1, 2010.

10A NCAC 220 .0408 INTERMEDIATE CARE FACILITIES (TRANSFERRED TO 10A NCAC 25D .0201(c)-(j))

10A NCAC 220 .0409 THERAPEUTIC LEAVE (TRANSFERRED TO 10A NCAC 25M .0501)

10A NCAC 220 .0410 PERSONAL CARE SERVICES (TRANSFERRED TO 10A NCAC 250 .0202(c)-(e))

SECTION .0100 – GENERAL INFORMATION

10A NCAC 22P .0101 PURPOSE AND SCOPE

History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d); Temporary Adoption Eff. December 28, 2010; Temporary Adoption Expired October 15, 2011.

SECTION .0200 – DEFINITIONS

10A NCAC 22P .0201 DEFINITIONS

History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d); Temporary Adoption Eff. December 28, 2010; Temporary Adoption Expired October 15, 2011.

SECTION .0300 – MEDICAL SERVICE REQUIREMENTS

10A NCAC 22P .0301 SERVICE DELIVERY

History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d); Temporary Adoption Eff. December 28, 2010; Temporary Adoption Expired October 15, 2011.

10A NCAC 22P .0302 ACCESS TO CARE

History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d); Temporary Adoption Eff. December 28, 2010; Temporary Adoption Expired October 15, 2011.

10A NCAC 22P .0303 COORDINATION OF BENEFITS

History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d); Temporary Adoption Eff. December 28, 2010; Temporary Adoption Expired October 15, 2011.

SECTION .0400 – CERTIFICATION AND STAFFING REQUIREMENTS

10A NCAC 22P .0401 CERTIFICATION REQUIREMENTS

History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d); Temporary Adoption Eff. December 28, 2010; Temporary Adoption Expired October 15, 2011.

10A NCAC 22P .0402 GOOD STANDING

History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d);

*Temporary Adoption Eff. December 28, 2010;
Temporary Adoption Expired October 15, 2011.*

10A NCAC 22P .0403 MEDICAL DIRECTOR REQUIREMENTS

*History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d);
Temporary Adoption Eff. December 28, 2010;
Temporary Adoption Expired October 15, 2011.*

10A NCAC 22P .0404 CLINICAL DIRECTOR

*History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d);
Temporary Adoption Eff. December 28, 2010;
Temporary Adoption Expired October 15, 2011.*

10A NCAC 22P .0405 QUALITY MANAGEMENT DIRECTOR

*History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d);
Temporary Adoption Eff. December 28, 2010;
Temporary Adoption Expired October 15, 2011.*

10A NCAC 22P .0406 TRAINING DIRECTOR

*History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d);
Temporary Adoption Eff. December 28, 2010;
Temporary Adoption Expired October 15, 2011.*

10A NCAC 22P .0407 EXCEPTION PROCESS

*History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d);
Temporary Adoption Eff. December 28, 2010;
Temporary Adoption Expired October 15, 2011.*

10A NCAC 22P .0408 MEDICAL SCHOOL/ TEACHING HOSPITAL EXCEPTION

*History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d);
Temporary Adoption Eff. December 28, 2010;
Temporary Adoption Expired October 15, 2011.*

SECTION .0500 – CERTIFICATION PROCEDURES

10A NCAC 22P .0501 LETTER OF ATTESTATION AND DESK REVIEW

*History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d);
Temporary Adoption Eff. December 28, 2010;
Temporary Adoption Expired October 15, 2011.*

10A NCAC 22P .0502 INTERVIEW

*History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d);
Temporary Adoption Eff. December 28, 2010;
Temporary Adoption Expired October 15, 2011.*

10A NCAC 22P .0503 VERIFICATION REVIEW

History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d);

Temporary Adoption Eff. December 28, 2010;
Temporary Adoption Expired October 15, 2011.

10A NCAC 22P .0504 EXISTING CRITICAL ACCESS BEHAVIORAL HEALTH AGENCIES

History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d);
Temporary Adoption Eff. December 28, 2010;
Temporary Adoption Expired October 15, 2011.

SECTION .0600 – MONITORING, DECERTIFICATION AND APPEAL PROCEDURES

10A NCAC 22P .0601 MONITORING

History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d);
Temporary Adoption Eff. December 28, 2010;
Temporary Adoption Expired October 15, 2011.

10A NCAC 22P .0602 DECERTIFICATION AND SUSPENSION

History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d);
Temporary Adoption Eff. December 28, 2010;
Temporary Adoption Expired October 15, 2011.

10A NCAC 22P .0603 APPEAL PROCEDURES

History Note: Authority G.S. 108A-54; 42 U.S.C. 1396a; 42 C.F.R. 431.51; S.L. 2009-451, Section 10.58(d);
Temporary Adoption Eff. December 28, 2010;
Temporary Adoption Expired October 15, 2011.

SUBCHAPTER 22Q - DISTRIBUTION OF FEDERAL DISPROPORTIONATE SHARE ADJUSTMENT RECEIPTS ARISING FROM CERTIFIED PUBLIC EXPENDITURES

10A NCAC 22Q .0101 SCOPE

This Subchapter establishes the requirements for the distribution of federal disproportionate share adjustment receipts as established by 42 CFR 447.298 arising from certified public expenditures.

History Note: Authority G.S. 108A-54; 143C-9-9;
Temporary Adoption Eff. December 29, 2021;
Eff. August 1, 2022.

10A NCAC 22Q .0102 DEFINITIONS

(a) "Certifying Hospital" means an institution that meets all of the following criteria:

- (1) meets the definition in G.S. 131E-176(13);
- (2) is licensed by the State of North Carolina; and
- (3) certifies as a public agency that its expenditures are eligible for Federal Financial Participation in accordance with 42 CFR 433.51(b), which is incorporated by reference, including subsequent amendments and editions. This document may be accessed at <https://www.ecfr.gov> at no charge.

(b) "Department" means the North Carolina Department of Health and Human Services.

(c) "Outpatient services" means those services as defined by 42 CFR 440.20(a), which is hereby incorporated by reference, including subsequent amendments and editions. This document can be accessed at <https://www.ecfr.gov> at no charge.

(d) "Uninsured patient" means medical care recipients who do not have health insurance, Medicaid or Medicare, or other third-party coverage. State or local government payments made to a hospital for services provided to indigent patients shall not be considered a source of third-party coverage.

(e) "Hospital Uncompensated Care Fund" means the fund established by G.S. 143C-9-9 and governed by 10A NCAC 22R.

(f) "Payment period" means the 12-month term ending September 30th of each year.

*History Note: Authority G.S. 108A-54; 143C-9-9;
Temporary Adoption Eff. December 29, 2021;
Eff. August 1, 2022.*

10A NCAC 22Q .0103 DISTRIBUTIONS

After distributions are made pursuant to an act appropriating funds for the operation of the North Carolina Medicaid Program and the "Basic Disproportionate Share Hospital (DSH) Payment" section of the North Carolina Medicaid State Plan, Attachment 4.19-A, which is incorporated by reference, including subsequent amendments and editions, and may be accessed free of charge at <https://medicaid.ncdhhs.gov/media/973/download?attachment>, the Department shall make distributions of the remaining DSH funds in the following order to:

- (1) Certifying hospitals; and
- (2) The Hospital Uncompensated Care Fund.

*History Note: Authority G.S. 108A-54; 143C-9-9;
Temporary Adoption Eff. December 29, 2021;
Eff. August 1, 2022.*

10A NCAC 22Q .0104 CERTIFYING HOSPITAL DISTRIBUTION

The Department shall distribute available funds to certifying hospitals in two parts:

- (1) An amount equal to 10 percent of expenditures certified by the hospital pursuant to 42 CFR 433.51; and
- (2) An amount equal to the hospital's proportionate share, calculated pursuant to Rule .0106 of this Section, of the available funds based on the hospital's share of outpatient costs for uninsured patients as a percentage of the Statewide aggregate of outpatient costs for uninsured patients. To be eligible for a proportionate share, a hospital shall file with the Department 90 days prior to the date of payment as determined by the Department, a form prescribed by the Department attesting to the hospital's:
 - (a) Qualification for disproportionate share status under the "Disproportionate Share Hospital (DSH) Payment" section of the North Carolina Medicaid State Plan, Attachment 4.19-A;
 - (b) Unreimbursed charges and payments for outpatient services provided to uninsured patients; and
 - (c) Aggregate Medicaid outpatient cost-to-charge ratio.

*History Note: Authority G.S. 108A-54; 143C-9-9;
Temporary Adoption Eff. December 29, 2021;
Eff. August 1, 2022.*

10A NCAC 22Q .0105 CERTIFYING HOSPITALS' OUTPATIENT COSTS

(a) A certifying hospital's outpatient costs for uninsured patients will be determined by multiplying the hospital's outpatient cost-to-charge ratio in Rule .0104(2)(c) of this Section by the hospital's outpatient charges for uninsured patients from Rule .0104(2)(b) of this Section.

(b) From the product calculated in Paragraph (a) of this Rule, the Department will then subtract payments that the hospital received from uninsured patients for outpatient services in Rule .0104(2)(b) of this Section.

(c) The Department will bring the uncompensated care cost data forward to the end of the payment period by applying the applicable Centers for Medicare and Medicaid Services' Prospective Payment System Hospital Input Price Indices, which are incorporated by reference, including subsequent amendments and editions and available at no cost at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData>.

*History Note: Authority G.S. 108A-54; 143C-9-9;
Temporary Adoption Eff. December 29, 2021;
Eff. August 1, 2022.*

10A NCAC 22Q .0106 CERTIFYING HOSPITAL'S PROPORTIONATE SHARE

The Department shall calculate the certifying hospital's proportionate share of outpatient costs as follows:

- (1) Adding the certifying hospitals' outpatient costs and each of the eligible hospitals' as defined in 10A NCAC 22R .0103, eligible outpatient costs under 10A NCAC 22R .0104. The sum represents the total of the outpatient costs.
- (2) The sum of all certifying hospitals' outpatient costs under Rule .0105 of this Section shall be divided by the total outpatient costs in Item (1) of this Rule. The quotient represents the certifying hospitals' proportionate share, expressed as a decimal.
- (3) The amount of available funds shall be multiplied by the certifying hospitals' proportionate share in Item (2) of this Rule. The product represents the funds available for distribution to individual certifying hospitals.
- (4) A certifying hospital shall be eligible for a payment from funds available for distribution in Item (3) of this Rule. In each payment period, a certifying hospital shall receive a proportional payment of the available funds based on the certifying hospital's share of outpatient costs for uninsured patients as a percentage of the aggregate of outpatient costs for uninsured patients for certifying hospitals.
- (5) Hospitals receiving payments pursuant to this Subchapter shall be subject to the audit and reporting requirements of the North Carolina Medicaid State Plan, Attachment 4.19-A.

History Note: Authority G.S. 108A-54; 108A-55(c); 143C-9-9;
Temporary Adoption Eff. December 29, 2021;
Eff. August 1, 2022.

SUBCHAPTER 22R - DISTRIBUTION OF HOSPITAL UNCOMPENSATED CARE FUND

10A NCAC 22R .0101 SCOPE

This Subchapter establishes the requirements for the distribution of funds allocated to the Hospital Uncompensated Care Fund pursuant to G.S. 143C-9-9 after distributions of available funds have been made pursuant to 10A NCAC 22Q.

History Note: Authority G.S. 108A-54; 143C-9-9;
Temporary Adoption Eff. December 29, 2021;
Eff. August 1, 2022.

10A NCAC 22R .0102 DEFINITIONS

- (a) "Department" means the North Carolina Department of Health and Human Services.
- (b) "Eligible hospital" means an institution that meets the requirements of Rule .0103 of this Section.
- (c) "Eligible hospital cost" means the values calculated pursuant to Rule .0104 of this Section.
- (d) "Hospital Uncompensated Care Fund" means the fund established by G.S. 143C-9-9 and governed by 10A NCAC 22R.
- (e) "Outpatient services" means the medical care and items as defined by 42 CFR 440.20(a), which is incorporated by reference in 10A NCAC 22Q .0102.
- (f) "Uninsured patient" means a recipient of medical care who has no health insurance, Medicaid or Medicare, or other third-party coverage. State and local government payments made to a hospital for services provided to indigent patients shall not be considered third-party coverage.
- (g) "Payment period" means the 12-month term ending September 30th of each year.

History Note: Authority G.S. 108A-54; 143C-9-9;
Temporary Adoption Eff. December 29, 2021;
Eff. August 1, 2022.

10A NCAC 22R .0103 ELIGIBLE HOSPITAL

An institution licensed by the State of North Carolina that meets the definition in G.S. 131E-176 (13) is eligible for reimbursement from the Hospital Uncompensated Care Fund if it:

- (1) is not a public agency qualified to certify expenditures in accordance 42 CFR 433.51(b), which is incorporated by reference in 10A NCAC 22Q .0102;
- (2) received payment for more than 50 percent of their Medicaid inpatient discharges under the North Carolina Medicaid State Plan, Attachment 4.19-A discharge Diagnosis Related Groups methodology for the most recent payment period;
- (3) files with the Department 90-days prior to the date of payment under this Subchapter forms prescribed by the Department attesting to the hospital's:
 - (a) qualification for disproportionate share status of the "Disproportionate Share Hospital (DSH) Payment" section of the North Carolina Medicaid State Plan, Attachment 4.19-A;
 - (b) unreimbursed charges and payments for outpatient services provided to uninsured patients; and
 - (c) aggregate Medicaid outpatient cost-to-charge.

History Note: Authority G.S. 108A-54; 143C-9-9;
Temporary Adoption Eff. December 29, 2021;
Eff. August 1, 2022.

10A NCAC 22R .0104 ELIGIBLE OUTPATIENT COSTS

- (a) An eligible hospital's eligible outpatient costs for uninsured patients will be determined by multiplying the hospital's outpatient cost-to-charge ratio in Rule .0103(3)(c) of this Section by the hospital's outpatient charges for uninsured patients from Rule .0103(3)(b) of this Section.
- (b) From the product calculated in Paragraph (a) of this Rule, the Department will then subtract payments that the hospital received from uninsured patients for outpatient services from Rule .0103(3)(b) of this Section.
- (c) The Department will bring the uncompensated care cost data forward to the end of the payment period by applying the applicable Centers for Medicare and Medicaid Services' Prospective Payment System Hospital Input Price Indices, which are incorporated by reference, including subsequent amendments and editions and available at no cost at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData>.

History Note: Authority G.S. 108A-54; 143C-9-9;
Temporary Adoption Eff. December 29, 2021;
Eff. August 1, 2022.

10A NCAC 22R .0105 DISTRIBUTION OF AVAILABLE FUNDS

- (a) An eligible hospital satisfying the requirements of Rule .0103 of this Section shall be eligible for a payment from funds available under this Subchapter. In a payment period, an eligible hospital shall receive a proportional payment of the available funds based on the eligible hospital's share of outpatient costs for uninsured patients as a percentage of the aggregate of outpatient costs for uninsured patients for all eligible hospitals.
- (b) Based on the availability of funds, payments authorized by this Rule shall be made at least annually on a frequency determined by the Department in consultation with certifying hospitals.
- (c) To confirm the hospital's eligibility to receive payments pursuant to this Subchapter and the accuracy of the hospital's attestation to unreimbursed charges for outpatient services provided to uninsured patients and the hospital's Medicaid outpatient cost-to-charge ratios, the Department may audit a hospital receiving more than two million dollars (\$2,000,000) for compliance with the requirements of this Subchapter. Upon completion of the audit, the following shall occur when applicable:
 - (1) If a hospital received payments pursuant to Paragraph (a) of this Rule in excess of the percentage determined by the audit, the excess payments shall be refunded to the Department.
 - (2) The Department shall distribute any refunded amounts to eligible hospitals, excluding eligible hospitals from whom excess distributions were recovered pursuant to Subparagraph (c)(1) of this Rule, within 12 months of receipt using the distribution method set forth Paragraph (a) of this Rule.
 - (3) No additional payment shall be made to eligible hospitals in connection with the audit except for the redistribution of amounts refunded after an audit conducted by the Division of Health Benefits.

*History Note: Authority G.S. 108A-54; 143C-9-9;
Temporary Adoption Eff. December 29, 2021;
Eff. August 1, 2022.*