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.