CHAPTER 75-02-05
PROVIDER INTEGRITY

SECTION 1. Section 75-02-05-03 is amended as follows:

75-02-05-03. Definitions.

In this chapter, unless the context or subject matter otherwise requires:

1. "Abuse" means practices that:

   a. Are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to Medicaid and children's health insurance program;

   b. Elicit reimbursement for services that are not medically necessary;

   c. Are in violation of an agreement or certificate of coverage; or

   d. Fail to meet professionally recognized standards for health care.

2. "Administrative or fiscal agent" means an organization which processes and pays provider claims on behalf of the department.

3. "Affiliates" means persons having an overt or covert relationship each with the other such that any one of them directly or indirectly controls or has the power to control another.

4. "Business integrity agreement" means an agreement between the department and the provider that addresses the concerns of the

department and recognizes essential elements of required compliance for the provider to preempt further sanction, exclusion from participation, or termination.

5. "Children's health insurance program" means a program to provide health assistance to low-income children funded through title XXI of the Social Security Act [42 U.S.C. 1397 aa et seq.].

6. "Client share" means the amount of monthly net income remaining after all appropriate deductions, disregards, and Medicaid income levels have been allowed. This is also referred to as recipient liability.

7. "Credible allegation of fraud" means an allegation which has been verified by the department.

8. "Department" means the department of human services' medical services, aging services, and developmental disabilities divisions.

9. "Direct owner" means someone with an active ownership interest in the disclosing entity.

10. "Disclosing entity" means a Medicaid or children's health insurance program provider, excluding an individual practitioner or group of practitioners, or a fiscal agent, that is required to provide ownership and enrollment information.

11. "Exclusion from participation" means permanent removal from provider participation in the North Dakota medical assistance or children's health insurance program.

12. "Fraud" means deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or another and includes an act that constitutes fraud under applicable federal or state law.

13. "Group of practitioners" means two or more health care practitioners who practice their profession at a common location.

14. "High-risk providers" means a provider or a provider type or specialty deemed by the department as high risk, based on federal regulations, policy, and guidance.

15. "Indirect ownership interest" means disclosing ownership interest in a disclosing entity, including an ownership interest in any entity that has an indirect ownership in the disclosing entity.

16. "Institutional provider" for purposes of assessing an application fee means those defined by centers for Medicare and Medicaid services or as deemed by the department based on federal regulations, policy, and guidance.

17. "Licensed practitioner" means an individual, other than a physician who is licensed or otherwise authorized by the state to provide health care services within the practitioner's scope of practice.

18. "Loss of contact" means that postal mail sent to an enrolled provider at the last known address is returned to the department.

19. "Managed care organization" means an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 C.F.R. part 438, and that is:

    a. A federally qualified health management organization that meets the advance directives requirements of 42 C.F.R. 489.102; or

    b. Any public or private entity that meets the advance directives requirements and is determined by the secretary of the federal department of health and human services, or designee, to also make the services it provides to program enrollees as accessible as those services are to other Medicaid and children's health insurance program recipients within the area served by the entity and meets the solvency standards of 42 C.F.R. 438.116.

~~19.~~20. "Medicaid" means "medical assistance" and is a term precisely equivalent thereto.

~~20.~~21. "Ownership interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

~~21.~~22. "Person" means any natural person, company, firm, association, corporation, or other legal entity.

~~22.~~23. "Provider" means any individual or entity furnishing Medicaid or children's health insurance program services under a provider agreement with the department or managed care organization.

~~23.~~24. "Provider specialty" means the area that a provider specializes in.

~~24.~~25. "Provider type" means a general type of service or provider.

~~25.~~26. "Sanction" means an action taken by the department against a provider for noncompliance with a federal or state law, rule, or policy, or with the

provisions of the Medicaid and children's health insurance program provider agreement.

~~26. "Suspension from participation" means temporary suspension of provider participation in the Medicaid program for a specified period of time.~~

27. "Suspend ~~Medicaid~~ payments" means the withholding of payments due a provider until the matter in dispute between the provider and the department is resolved.

28. "Suspension from participation" means temporary suspension of provider participation in the Medicaid program for a specified period of time.

~~28.~~29. "Termination" means determining a provider to be indefinitely ineligible to be a Medicaid and children's health insurance program provider.

History: Effective July 1, 1980; amended effective July 1, 2012; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-29-02
Law Implemented: 42 CFR 431.107

SECTION 2. Section 75-02-05-04 is amended as follows:

75-02-05-04. Provider responsibility.

To assure quality medical care and services, Medicaid and children's health insurance program payments may be made only to providers meeting established standards. Providers who are certified for participation in Medicare are eligible for participation, providing no sanction has been imposed as provided for in section 75-02-05-08. Comparable standards for providers who do not participate in Medicare are established by state law and appropriate licensing and standard-setting authorities in the health and mental health fields.

1. Payment for ~~covered~~ services under Medicaid and children's health insurance program is limited to those covered services that are medically necessary for the proper management, control, or treatment of an individual's medical problem and provided under the physician's or licensed practitioner's direction and supervision.

2. Each provider agrees to retain documentation to support medical services rendered for a minimum of seven years and, upon request, to make the documentation available to persons acting on behalf of the department and the United States department of health and human services. A provider shall provide the records at no charge.

3. A provider must accept, as payment in full, the amounts paid in accordance with the payment structure established by the department. A provider performing a procedure or service may not request or receive any

payment, in addition to the amounts established by the department, from the recipient, or anyone acting on the recipient's behalf, for the same procedure or service. In cases where a client share has been properly determined by a ~~county social service board~~human service zone, the provider may hold the recipient responsible for the client share.

4. A provider may not bill a recipient for services that are allowable under Medicaid or children's health insurance program, but not paid due to the provider's lack of adherence to Medicaid or children's health insurance program requirements.

5. If an enrolled Medicaid or children's health insurance program provider does not bill Medicaid for certain services, the enrolled Medicaid or children's health insurance program provider must notify all recipients of any limitation and secure acknowledgment, in writing. If the provider expressly informs the recipient, or in the case of a child, the recipient's parent or guardian, that provider would not accept Medicaid or children's health insurance program payment for certain services, the provider may bill the recipient as a private-pay client for the services.

6. No Medicaid or children's health insurance program payment will be made for claims received by the department later than twelve months following the date the service was provided. Claim adjustments submitted within twelve months of the most recent processed claim shall be considered timely.

7. The department will process claims six months past the Medicare explanation of benefits date if the provider followed Medicare's timely filing policy.

8. In all joint Medicare/Medicaid cases, a provider must accept assignment of Medicare payment to receive payment from Medicaid for amounts not covered by Medicaid and children's health insurance program.

9. When the recipient has other medical insurance, all benefits available due from that other insurance must be applied prior to the provider accepting payment by Medicaid.

10. A provider may not offer or accept a fee, portion of a fee, charge, rebate, or kickback for a Medicaid or children's health insurance program patient referral.

11. Claims for payment and documentation must be submitted as required by the department or its designee.

12. A provider shall comply with all accepted standards of professional conduct and practice in dealing with recipients and the department.

13. Each provider shall comply with all applicable centers for Medicare and Medicaid services regulations.

14. Each provider shall comply with requests for documentation from the provider's practice, that may include patient information for non-Medicaid or non-children's health insurance program recipients, which allows department staff or its authorized agent to evaluate overall scheduling, patient-to-provider ratios, billing practices, or evaluating the feasibility of services provided per day.

History: Effective July 1, 1980; amended effective July 1, 2012; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-29-02
Law Implemented: 42 CFR 431.107

SECTION 3. Section 75-02-05-04.2 is created as follows:

75-02-05-04.2. Termination of provider enrollment.

The department may terminate the enrollment of a Medicaid or children's health insurance program provider under the following circumstances:

1. The individual is enrolled to provide transportation, but does not possess a current driver's license or has a driver's license which has been suspended or revoked;

2. The enrolled provider fails to revalidate their enrollment per federal requirements and according to the reenrollment schedule established by the department;

3. The enrolled provider or practitioner does not submit a Medicaid or children's health insurance program claim to the department for twenty-four months or more;

4. There is a loss of contact with the enrolled provider; or

5. As a result of sanction imposed in accordance with section 75-02-05-07.

History: Effective April 1, 2020.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-24.1-36, 50-29-02
Law Implemented: NDCC 50-24.1-36, 42 CFR 431.107

SECTION 4. Section 75-02-05-07 is amended as follows:

75-02-05-07. Activities leading to and including sanction.

1. a. When the department determines that a provider has been rendering care or services in a form or manner inconsistent with program requirements or rules, or has received payment for which the provider may not be properly entitled, the department shall notify the provider in writing of the discrepancy noted. The notice to the provider may set forth:

(1) The nature of the discrepancy or inconsistency.

(2) The dollar value, if any, of such discrepancy or inconsistency.

(3) The method of computing such dollar values.

(4) Further actions which the department may take.

(5) Any action which may be required of the provider.

b. When the department has notified the provider in writing of a discrepancy or inconsistency, it may withhold payments on pending and future claims awaiting a response from the provider.

2. If the department determines that a provider's claims were not submitted properly or that a provider has engaged in suspected fraud or abuse, the department may require the provider to participate in and complete an educational program.

a. If the department decides that a provider should participate in an educational program, the department shall provide written notice to the provider, by certified mail, setting forth the following:

(1) The reason the provider is being directed to attend the educational program;

(2) The educational program determined by the department; and

(3) That continued participation as a provider in Medicaid and children's health insurance program is contingent upon completion of the educational program identified by the department.

b. An educational program may be presented by the department. The educational program may include:

(1) Instruction on the correct submission of claims;

(2) Instruction on the appropriate utilization of services;

(3) Instruction on the correct use of provider manuals;

(4) Instruction on the proper use of procedure codes;

(5) Education on statutes, rules, and regulations governing the Medicaid and children's health insurance program;

(6) Education on reimbursement rates and payment methodologies;

(7) Instructions on billing or submitting claims; and

(8) Other educational tools identified by the department.

3. If a provider who is required to participate in an educational program refuses to participate in that program, the department shall suspend the provider from participation in Medicaid and children's health insurance program until the provider successfully completes the required program. The time frame to successfully complete the educational program may be extended upon provider request and with department approval.

4. If the department determines that a provider's claims were not submitted properly or that a provider has engaged in suspected fraud or abuse, the department may require the provider to implement a business integrity agreement. If the department requires a provider to enter a business integrity agreement and the provider refuses, the department shall ensure the provider is suspended from participation in Medicaid and children's health insurance program until the provider implements the required agreement.

5. The department shall suspend ~~Medicaid~~ payments to a provider after the department determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid and children's health insurance program unless the provider has demonstrated good cause why the department should not suspend ~~Medicaid~~ payments or should suspend ~~Medicaid~~ payment only in part. If the provider also is enrolled in a managed care organization under contract with the department, the managed care organization must suspend all Medicaid payments to the provider.

6. The department may not make payments to a provider who is not complying with a department directed repayment plan. Recoveries may be taken across any Medicaid program payment and delivery system.

7. The director of the medical services division, or the director's designee, shall determine the appropriate sanction for a provider under this chapter. The following may be considered in determining the sanction to be imposed:

a. Seriousness of the provider's offense.

b. Extent of the provider's violations.

c. Provider's history of prior violations.

d. Prior imposition of sanctions against the provider.

e. Prior provision of information and training to the provider.

f. Provider's agreement to make restitution to the department.

g. Actions taken or recommended by peer groups or licensing boards.

h. Access to care for recipients.

i. Provider's self-disclosure or self-audit discoveries.

j. Provider's willingness to enter a business integrity agreement.

~~7.~~ 8. When a provider has been excluded from the Medicare program, the provider will also be terminated or excluded from participation in the Medicaid and children's health insurance program.

~~8.~~ 9. If the division determines there is a credible allegation of fraud, the division may impose any one or a combination of the following temporary sanctions:

a. Prepayment review of claims;

b. Postpayment review of claims;

c. Recovery of costs associated with an investigation;

d. Requirement of a provider self-audit;

e. Notification and referral to the appropriate state regulatory agency or licensing agency;

f. Suspension from participation in the Medicaid or children's health insurance program, including providers operating under an arrangement with a managed care organization;

g. Suspend ~~Medicaid~~ payments to a provider;

h. Prior authorization of all services; and

i. Peer review at the provider's expense.

~~9.~~10. After the completion of a further investigation, the department shall document its findings in writing and provide a copy of that documentation to the provider. Following a determination by the department that the provider has engaged in fraud or abuse; the department may terminate, exclude or impose sanctions with conditions, including the following:

a. Recovery of overpayments;

b. Recovery of excess payments;

c. Recovery of costs associated with an investigation;

d. Requirement of a provider self-audit;

e. Prepayment review of claims;

f. Postpayment review of claims;

g. Notification and referral to the appropriate state regulatory agency or licensing agency;

h. Prior authorization of all services;

i. Penalties as established by the department; and

j. Peer review at the provider's expense.

~~10.~~11. A sanction may be applied to all known affiliates of a provider, provided that each sanctioned affiliate knew or should have known of the violation.

~~11.~~12. A provider subject to termination or exclusion from participation may not submit claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association to the department, its fiscal agent or managed care organization for any services or supplies provided under the Medicaid or children's health insurance program

except for any services or supplies provided prior to the effective date of the termination or exclusion.

~~12.~~13. A clinic, group, corporation, or other organization which is a provider may not submit claims for payment to the department or its fiscal agent for any services or supplies provided by a person within the clinic, group, corporation, or organization who has been terminated or is under exclusion from participation in this state or any other state or who has been excluded from Medicare except for those services or supplies provided prior to the effective date of the termination or exclusion.

~~13.~~14. When the department determines there is a need to sanction a provider, the director of the medical services division, or the director's designee, shall notify the provider in writing of the sanction imposed. The notice must advise the provider of the right to a review, when applicable.

~~14.~~15. After the department sanctions a provider, the director of the medical services division may notify the applicable professional society, board of registration or licensure, and any appropriate federal, state, human service zone, or county agency of the reasons for the sanctions and the sanctions imposed.

~~15.~~16. If the department sanctions a provider who also serves as a billing agent for other providers, the department may also impose sanctions against the other providers upon a finding that the actions performed as the billing agent fails to meet department standards.

History: Effective July 1, 1980; amended effective July 1, 2012; April 1, 2014; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-24.1-36, 50-29-02
Law Implemented: NDCC 50-24.1-04, 50-24.1-36; 42 CFR 455.13, 42 CFR 455.14, 42 CFR 455.15, 42 CFR 455.16, 42 CFR 455.17, 42 CFR 455.23

SECTION 5. Section 75-02-05-09 is amended as follows:

75-02-05-09. Review and appeal.

1. A provider may not request a review of a temporary sanction until further investigation has been completed and the department has made a final decision.

2. After completion of further investigation, if there is an imposition of a subsequent sanction, the provider may request a review of the sanction pursuant to subsection 6 of North Dakota Century Code section 50-24.1-36.

3. A provider who is aggrieved by the decision the department issues in response to a request for review may appeal as set forth in subsection 6 of North Dakota Century Code section 50-24.1-36.

4. An applicant may appeal a decision to deny enrollment or terminate provider enrollment by filing a written appeal with the department within fifteen days of the date of the written notice of the denial or termination. Upon receipt of a timely appeal, an administrative hearing may be conducted in the manner provided in chapter 75-01-03. An applicant who receives notice of denial and requests a timely review of that decision is not eligible to provide services until a final decision has been made by the department that reverses the decision to deny the application.

History: Effective July 1, 1980; amended effective July 1, 2012; April 1, 2014; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-06-01.9, 50-09-02, 50-24.1-04
Law Implemented: NDCC 23-01-03, 23-16-01, 23-17.1-01, 23-20.1-04, 23-27-01, 25-16-02, 26.1-18-02, 43-05-09, 43-06-08, 43-12.1-03, 43-13-15, 43-15-15, 43-17-34, 43-26-13, 43-28-10, 43-32-17, 43-33-02, 43-37-03, 50-11.1-03, 50-24.1-36; NDAC 75-01-03; 42 USC 1396a(a)(39); 42 CFR 431.151; 42 CFR 455.13