CHAPTER 75-02-05
PROVIDER INTEGRITY

SECTION 1. 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 75-02-05-07. 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 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 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 original claims received by the department later than ~~twelve months following~~one hundred eighty days from the date ~~the~~of service ~~was provided~~. ~~Claim~~Final claim adjustments must be submitted within ~~twelve months of the most recent processed claim shall be considered timely~~three hundred sixty-five days from the date of service. The department may grant a variance to extend the deadline for a provider to submit a final claim adjustment. A refusal to grant a variance is not subject to a request for review or an appeal.

7. The department will process claims ~~six months past the Medicare explanation of benefits date~~within one hundred eighty days from the date on the Medicare explanation of benefits 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; January 1, 2022.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-29-02
Law Implemented: 42 CFR 431.107