CHAPTER 75-02-02
MEDICAL SERVICES

SECTION 1. Section 75-02-02-03.2 is amended as follows:

75-02-02-03.2. Definitions. For purposes of this chapter:

1. "Certification of need" means a regulatory review process that requires specific health care providers to obtain prior authorization for provision of services for medicaid applicants or eligible recipients under twenty-one years of age. Certification of need is a determination of the medical necessity of the proposed services as required for all applicants or recipients under the age of twenty-one prior to admission to a psychiatric hospital, an inpatient psychiatric program in a hospital, or a psychiatric facility, including a psychiatric residential treatment facility. The certification of need evaluates the individual's capacity to benefit from proposed services, the efficacy of proposed services, and consideration of the availability of less restrictive services to meet the individual's needs.
2. "County agency" means the county social service board.
3. "Department" means the North Dakota department of human services.
4. "Drug use review board" means the board established pursuant to North Dakota Century Code chapter 50-24.6.
5. "Home health agency" means a public or private agency or organization, or a subdivision of such an agency or organization, which is qualified to participate as a home health agency under title XVIII of the Social Security Act, or is determined currently to meet the requirements for participation.
6. "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.
7. "Medical emergency" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
8. "Medically necessary" includes only medical or remedial services or supplies required for treatment of illness, injury, diseased condition, or impairment; consistent with the patient's diagnosis or symptoms; appropriate according to generally accepted standards of medical practice; not provided only as a convenience to the patient or provider; not investigational, experimental, or unproven; clinically appropriate in terms of scope, duration, intensity, and site; and provided at the most appropriate level of service that is safe and effective.
9. "Provider" means an individual, entity, or facility furnishing medical or remedial services or supplies pursuant to a provider agreement with the department.
10. "Psychiatric residential treatment facility" is as defined in subsection 10 of section 75-03-17-01.

11. "Psychological service" means an evaluation therapy of testing service rendered by a physician, licensed independent clinical social worker, psychologist, speech therapist, licensed addiction counselor, licensed associate counselor, licensed professional counselor, licensed professional clinical counselor, clinical nurse specialist, physician assistant, or nurse practitioner.

12. "Recipient" means an individual approved as eligible for medical assistance.

~~12.~~13. "Rehabilitative services" means any medical remedial items or services prescribed for a patient by the patient's physician or other licensed practitioner of the healing arts, within the scope of the physician's or practitioner's practice as defined by state law, for the purpose of maximum reduction of physical or mental disability and restoration of the patient to the patient's best possible functional level.

~~13.~~14. "Remedial services" includes those services, including rehabilitative services, which produce the maximum reduction in physical or mental disability and restoration of a recipient to the recipient's best possible functional level.

~~14.~~15. "Section 1931 group" includes individuals whose eligibility is based on the provisions of section 1931 of the Social Security Act [42 U.S.C. 1396u-1].

History: Effective May 1, 2000; amended effective August 29, 2000; November 1, 2001; September 1, 2003; October 1, 2012; April 1, 2016.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-01

SECTION 2. Subdivision o of subsection 1 of section 75-02-02-08 is amended as follows:

75-02-02-08. Amount, duration, and scope of medical assistance.

1. Within any limitations which may be established by rule, regulation, or statute and within the limits of legislative appropriations, eligible recipients may obtain the medically necessary medical and remedial care and services which are described in the approved medicaid state plan in effect at the time the service is rendered by providers. Services may include:

   o. Services for individuals with speech, hearing, and language disorders. "Services for individuals with speech, hearing, and language disorders" means those diagnostic, screening, preventive, or corrective services provided by or under the supervision of a speech pathologist or audiologist in the scope of practice of the speech pathologist's or audiologist's profession for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.

History: Amended effective September 1, 1978; September 2, 1980; February 1, 1981; November 1, 1983; May 1, 1986; November 1, 1986; November 1, 1987; January 1, 1991; July 1, 1993; January 1, 1994; January 1, 1996; July 1, 1996; January 1, 1997; May 1, 2000; amendments partially voided by the Administrative Rules Committee effective June 5, 2000; November 8, 2002; September 1, 2003; July 1, 2006; January 1, 2010; July 1, 2012; October 1, 2012; July 1, 2014; April 1, 2016.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 USC 1396n(b)(1); 42 CFR 431.53; 42 CFR 431.110; 42 CFR 435.1009; 42 CFR Part 440; 42 CFR Part 441, subparts A, B, D

SECTION 3. Subdivisions g and n of subsection 2 of section 75-02-02-08 is amended as follows:

75-02-02-08. Amount, duration, and scope of medical assistance.

2. The following limitations apply to medical and remedial care and services covered or provided under the medical assistance program:

   g. Coverage and payment for home health care services and private duty nursing services are limited to ~~a monthly amount determined by taking the monthly charge, to the medical assistance program, for the most intensive level of nursing care in the most expensive nursing facility in the state and subtracting therefrom the cost, in that month, of all medical and remedial services furnished to the recipient (except physician services and prescribed drugs). For the purposes of determining this limit, remedial services include home and community-based services, service payments to the elderly and disabled, homemaker and home health aide services, and rehabilitative services, regardless of the source of payment for such services~~ no more, on an average monthly basis, to the equivalent of one hundred seventy-five visits. The limit for private duty nursing is in combination with the limit for home health services. Services are limited to the home of the recipient.
      (1) This limit may be exceeded~~,~~ in ~~unusual and complex~~ cases~~,~~ ~~if the provider has submitted~~ where it is determined there is a medical necessity for exceeding the limit and the department has approved a prior treatment authorization request.
      (2) The prior authorization request must describe the medical necessity of the home health care services or private duty nursing services, and explain why less costly alternative treatment does not afford necessary medical care.

   n. Coverage and payment for pharmacy services are limited to:
      (1) The lower of the estimated acquisition costs plus reasonable dispensing fees established by the department;

(2) The provider's usual and customary charges to the general public; or

(3) The federal upper limit or maximum allowable cost plus reasonable dispensing fees established by the department. For the department to meet the requirements of 42 CFR 447.331-447.333, pharmacy providers agree when enrolling as a provider to fully comply with any acquisition cost survey and any cost of dispensing survey completed for the department or centers for medicare and medicaid services. Pharmacy providers agree to provide all requested data to the department, centers for medicare and medicaid services, or their agents, to allow for calculation of estimated acquisition costs for drugs as well as estimated costs of dispensing. This data will include wholesaler invoices and pharmacy operational costs. Costs can include salaries, overhead, and primary wholesaler invoices if a wholesaler is partially or wholly owned by the pharmacy or parent company or has any other relationship to the pharmacy provider.

History: Amended effective September 1, 1978; September 2, 1980; February 1, 1981; November 1, 1983; May 1, 1986; November 1, 1986; November 1, 1987; January 1, 1991; July 1, 1993; January 1, 1994; January 1, 1996; July 1, 1996; January 1, 1997; May 1, 2000; amendments partially voided by the Administrative Rules Committee effective June 5, 2000; November 8, 2002; September 1, 2003; July 1, 2006; January 1, 2010; July 1, 2012; October 1, 2012; July 1, 2014; April 1, 2016.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 USC 1396n(b)(1); 42 CFR 431.53; 42 CFR 431.110; 42 CFR 435.1009; 42 CFR Part 440; 42 CFR Part 441, subparts A, B, D

SECTION 4. Section 75-02-02-09.1 is amended as follows:

75-02-02-09.1. Cost sharing.

1. Copayments provided for in this section may be imposed unless:
   a. The recipient receiving the service:
      (1) ~~Lives~~ Is in a nursing facility, intermediate care facility for individuals with intellectual disabilities, or ~~the state hospital~~ any medical institution and is required to spend all income except for the recipient's personal needs allowance for the recipient's cost of care;
      (2) Receives swing-bed services in a hospital;
      (3) Has not reached the age of twenty-one years;
      (4) Is pregnant;
      (5) Is an Indian who ~~receives services from~~ is eligible to receive, is currently receiving, or who has ever received an item or service furnished by Indian health service providers or through referral ~~by~~ under contract health services; ~~or~~

(6) Is terminally ill and is receiving hospice care;
(7) Is receiving medical assistance because of the state's election to extend coverage to eligible individuals receiving treatment for breast or cervical cancer;
(8) Is an inmate, otherwise eligible for medical assistance, and is receiving qualifying inpatient services.

b. The service is:
(1) Emergency room services that are not elective or not urgent; or
(2) Family planning services.

2. Copayments are:
a. Seventy-five dollars for each inpatient hospital admission, including admissions to distinct part psychiatric and rehabilitation units of hospitals and excluding long-term hospitals;
b. Three dollars for each nonemergency visit to a hospital emergency room;
c. Two dollars for each ~~doctor of medicine or osteopathy~~ office visit for care by a physician, nurse practitioner, physician assistant, nurse mid-wife, clinical nurse specialist, behavioral health provider, optometrist, or optician;
d. Three dollars for each office visit to a rural health clinic or federally qualified health center;
e. One dollar for each chiropractic manipulation of the spine;
f. Two dollars for each dental visit that includes an oral examination;
g. Three dollars for each brand name prescription filled;
h. Two dollars for each optometric visit that includes a vision examination;
i. Three dollars for each podiatric office visit;
j. Two dollars for each occupational therapy visit;
k. Two dollars for each physical therapy visit;
l. One dollar for each speech therapy visit;
m. Three dollars for each hearing aid dispensing service;
n. Two dollars for each audiology testing visit;
o. Two dollars for each psychological service visit; and
p. Two dollars for each licensed independent clinical social worker visit.

History: Effective January 1, 1997; amended effective November 8, 2002; September 1, 2003; July 1, 2006; July 1, 2012; October 1, 2012; April 1, 2016.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

SECTION 5. Subsection 3 of section 75-02-02-03.2 is amended as follows:

75-02-02-09.3. Limitations on payment for dental services.

3. Payment will be made for partial dentures for upper and lower temporary partial stayplate dentures. Payment may be made for other types of partial dentures designed to replace teeth in the anterior portion of the mouth if the provider secures prior approval from the department. Replacement of dentures is limited to every five years unless a medical condition of a recipient, verified by a dental consultant, ~~rends~~renders the present dentures unusable. This limitation does not apply to individuals eligible for the early, periodic screening, diagnosis, and treatment program.

History: Effective September 1, 2003; amended effective October 1, 2012; April 1, 2016.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

SECTION 6. Section 75-02-02-03.2 is amended as follows:

75-02-02-09.4. General limitations on amount, duration, and scope.

1. Covered medical or remedial services or supplies are medically necessary when determined so by the medical provider unless the department has:
   a. Denied a prior treatment authorization request to provide the service;
   b. Imposed a limit that has been exceeded;
   c. Imposed a condition that has not been met;
   d. Upon review under North Dakota Century Code chapter 50-24.1, determined that the service or supplies are not medically necessary.
2. Limitations on payment for occupational therapy, physical therapy, and speech therapy.
   a. No payment will be made for occupational therapy evaluation except one per calendar year or for occupational therapy provided to an individual except for twenty visits per individual per calendar year unless the provider requests and receives prior authorization from the department. This limit applies in combination ~~to~~ with services delivered by independent occupational therapists and in outpatient hospital settings. This limit does not apply to school-based services for children.
   b. No payment will be made for physical therapy evaluation except one per calendar year or for physical therapy provided to an individual except for fifteen visits per individual per calendar year unless the provider requests and receives prior authorization from the department. This limit applies in combination ~~to~~ with services delivered by independent physical therapists and in outpatient hospital settings. This limit does not apply to school-based services for children.
   c. No payment will be made for speech therapy evaluation except one per calendar year or for speech therapy provided to an individual except for thirty visits per individual per calendar year unless the provider requests and receives prior authorization from the

department. This limit applies in combination ~~to~~ with services delivered by independent speech therapists and in outpatient hospital settings. This limit does not apply to school-based services for children.

3. Limitation on payment for eye services.
   a. No payment will be made for eyeglasses for individuals twenty-one years of age and older except for one pair of eyeglasses no more often than once every two years. No payment will be made for the repair or replacement of eyeglasses during the two-year period unless the provider has secured the prior approval of the department and the department has found that the repair or replacement is medically necessary.
   b. No payment will be made for refractive examinations for individuals twenty-one years of age and older except for one refractive examination no more often than every two years after an initial examination paid by the department unless the provider has secured the prior approval of the department.
4. Limitation on chiropractic services.
   a. No payment will be made for spinal manipulation treatment services except for twelve spinal manipulation treatment services per individual per calendar year unless the provider requests and receives the prior approval of the department.
   b. No payment will be made for radiologic examinations performed by a chiropractor except for two radiologic examinations per individual per year unless the provider requests and receives the prior approval of the department.
5. No payment will be made for psychological visits except for forty visits per individual per calendar year; or for psychological evaluations except for one per calendar year; or psychological testing except for four units per calendar year unless the provider requests and receives the prior approval of the department.

History: Effective September 1, 2003; amended effective July 1, 2006; July 1, 2009; October 1, 2012; April 1, 2016.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

SECTION 7. Subsection 6 of section 75-02-02-03.2 is amended as follows:

75-02-02-09.5. Limitations on personal care services.

6. An inpatient or resident of a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, a psychiatric residential treatment facility, or an institution for mental diseases may not receive personal care services.

History: Effective July 1, 2006; amended effective January 1, 2010; July 1, 2012; October 1, 2012; April 1, 2016.
General Authority: NDCC 50-24.1-18
Law Implemented: NDCC 50-24.1-18; 42 CFR Part 440.167

SECTION 8. Subsections 1 and 5 of section 75-02-02-03.2 is amended as follows:

75-02-02-11. Coordinated services.

1. For purposes of this section:
   a. "Coordinated services" means the process used to limit a recipient's medical care and treatment to a single physician or other provider to prevent the continued misutilization of services.
   b "Coordinated services provider" means a physician, nurse practitioner, physician assistant, or Indian health service provider selected by the coordinated services recipient to provide care and treatment to the recipient. The selected coordinated services provider is subject to approval by the department.
   c. "Misutilization" means the incorrect, improper, or excessive utilization of medical services which may increase the possibility of adverse effects to a recipient's health or may result in a decrease in the overall quality of care.

5. If a coordinated services recipient does not select a coordinated services provider within thirty days after qualifying for the program, the department will ~~assign a coordinated services provider on the recipient's behalf. If the department assignment for the coordinated services program is necessary, the most utilized providers that the recipient has visited during the preceding six months will be designated as the recipient's coordinated services provider~~ limit the recipient to only medically necessary medical and pharmacy services. If a coordinated services recipient selects a coordinated services provider after the initial thirty days, the selection will be reviewed by the department to determine if the selected provider is appropriate and to ensure the provider accepts the assignment. A coordinated services recipient may have a coordinated services provider in more than one medical specialty.

History: Effective May 1, 1981; amended effective May 1, 2000; July 1, 2006; October 1, 2012; April 1, 2016.
General Authority: NDCC 50-24.1-02
Law Implemented: NDCC 50-24.1-01; 42 CFR Part 455

SECTION 9. Subsection 2 of section 75-02-02-03.2 is amended as follows:

75-02-02-12. Limitations on emergency room services.

2. Except in life-threatening situations, the nonphysician provider of emergency services shall assure:

a. The collection of pertinent data from the patient;
b. Screening or examination of the patient as necessary to determine the patient's medical condition;
c. Rendering of indicated care, under the direction of a physician or licensed practitioner of the healing arts, within their scope of practice, if a medical emergency exists;
d. An attempt is made to contact the recipient's personal primary care provider to approve services before they are given;
e. Referral to the recipient's primary care provider's office in cases when emergency room services are not indicated; and
f. That professional staff persons use their individual judgment in determining the need for emergency services.

History: Effective February 1, 1982; amended effective May 1, 2000; October 1, 2012; April 1, 2016.
General Authority: NDCC 50-24.1-02
Law Implemented: NDCC 50-24.1-01; 42 CFR Part 455

SECTION 10. Section 75-02-02-03.2 is amended as follows:

75-02-02-13.1. Travel expenses for medical purposes - Limitations.

1. For purposes of this section:
   a. "Family member" means spouse, sibling, parent, stepparent, child, stepchild, grandparent, stepgrandparent, grandchild, stepgrandchild, aunt, uncle, niece, or nephew, whether by half or whole blood, and whether by birth, marriage, or adoption; and
   b. "Travel expenses" means fares, mileage, meals, lodging, and driver and attendant care.
2. General requirements.
   a. A transportation service provider shall be enrolled as a provider in the medical assistance program and may be an individual, a taxi, a bus, a food service provider, a lodging provider, an airline service provider, a travel agency, or another commercial form of transportation.
   b. The county agency may determine the most efficient, economical, and appropriate means of travel to meet the medical needs of the recipient. Upon approval, the county agency may approve travel and issue the necessary billing forms.
   c. The cost of travel provided by a parent, spouse, or any other member of the recipient's medical assistance unit may be allowed as an expense of necessary medical or remedial care for recipient liability purposes. No parent, spouse, friend, household member, or family member of the recipient may be paid as an enrolled provider for transportation for that recipient. An individual who provides foster care, kinship, or guardianship may enroll as a transportation provider and is eligible for reimbursement to transport a medicaid-eligible child to and from medicaid-covered medical appointments.

d. Travel services may be provided by the county agency as an administrative activity.

e. Emergency transport by ambulance is a covered service when provided in response to a medical emergency.

f. Nonemergency transportation by ambulance is a covered service only when medically necessary and ordered by the attending licensed provider.

g. A recipient may choose to obtain medical services outside the recipient's community. If similar medical services are available within the community and the recipient chooses to seek medical services elsewhere, travel expenses are not covered services and are the responsibility of the recipient.

h. If a ~~primary care~~ provider refers a recipient to a facility or provider that is not located at the closest medical center, travel expenses are not covered services and are the responsibility of the recipient, unless special circumstances apply and prior authorization is secured.

3. Out-of-state travel expenses. Travel expenses for nonemergency out-of-state medical services, including ~~followup~~ follow-up visits, may be authorized if the out-of-state medical services are first approved by the department under section 75-02-02-13 or if prior approval is not required under that section.

4. Limitations.

a. Private or noncommercial vehicle mileage compensation is limited to an amount set by the department based on the department's fee schedule. This limit applies even if more than one recipient is transported at the same time. Mileage is determined by map miles from the residence or community of the recipient to the medical facility. When necessary to ensure volunteer drivers continue to provide transportation services to a recipient, the county agency may request authorization from the department to make payment for additional mileage. Transportation services may be billed to medical assistance only upon completion of the service. Transportation services may be allowed if the recipient or a household member does not have a vehicle that is in operable condition or if the health of the recipient or household member does not permit safe operation of the vehicle. If free or low-cost transportation services are available, including transportation that could be provided by a friend, family member, or household member, the department will not pay transportation ~~mileage~~ costs.

b. Meals compensation is allowed only when medical services or travel arrangements require a recipient to stay overnight. Compensation is limited to an amount set by the department based on the department's fee schedule. The entity providing meals must be an enrolled medicaid provider and must submit the proper forms for payment.

c. Lodging expense is allowed only when medical services or travel arrangements require a recipient to stay overnight. Lodging compensation is limited to an amount set by the department, based on the appropriate fee schedule. Lodging providers must be enrolled in medicaid and shall submit the proper forms for payment.

d. Travel expenses may not be authorized for both a driver and an attendant unless the referring licensed practitioner determines that one individual cannot function both as driver and attendant. Travel expenses may not be allowed for a noncommercial driver or an attendant while the recipient is a patient in a medical facility unless it is more economical for the driver or attendant to remain in the service area, as determined by the department.

e. Travel expenses may be authorized for one parent to travel with a child who is under eighteen years of age. No additional travel expenses may be authorized for another driver, attendant, or parent unless the referring licensed practitioner determines that person's presence is necessary for the physical, psychological, or medical needs of the child.

f. Compensation for attendant services, provided by an attendant who is not a family member, may be allowed at a rate determined by the department if the department determines attendant services are medically necessary. Attendant services must be approved by the county agency.

History: Effective July 1, 1996; amended effective May 1, 2000; September 1, 2003; October 1, 2012; July 1, 2014; April 1, 2016.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

SECTION 11. Subsection 3 of section 75-02-02-03.2 is amended as follows:

75-02-02-13.2. Travel expenses for medical purposes – Institutionalized individuals - Limitations.

3. If the resident has to travel farther than the nearest medical center city ~~with a medical center~~, the costs of travel may be reimbursed by medicaid according to the appropriate fee schedule. Distance must be calculated by map miles.

History: Effective July 1, 1996; amended effective July 1, 2012; October 1, 2012; April 1, 2016.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

SECTION 12. Section 75-02-02-03.2 is amended as follows:

75-02-02-29. Primary care provider.

1. Payment may not be made, except as provided in this subsection, for otherwise covered services provided to otherwise eligible recipients:
   a. Who are required by this subsection to select, but who have not selected, or have not had selected on their behalf, a primary care provider; or
   b. By a provider who is not the primary care provider selected by or on behalf of the recipient or to whom the recipient has not been referred from the primary care provider.
2. A primary care provider must be selected by or on behalf of the members ~~of a~~ in the following medical assistance ~~unit which includes~~ units:
   a. ~~A person who is a member of the section 1931 group.~~
   ~~b.~~ ~~A family who was in the section 1931 group in at least three of the six months immediately preceding the month in which the family became ineligible as a result, in whole or in part, of the collection or increased collection of child or spousal support, and who continues to be eligible for medicaid for four calendar months following the last month of section 1931 group eligibility.~~
   ~~c.~~ ~~A family who was in the section 1931 group in at least three of the six months immediately preceding the month in which the family became ineligible solely because of hours of, or income from, employment of the caretaker relative; or who became ineligible because a member of the family lost the time-limited disregards which is the percentage disregard of earned income.~~
   ~~d.~~ ~~A child born to an eligible pregnant woman who has applied for and been found eligible for medicaid on or before the day of the child's birth, for sixty days after the day of the child's birth, and for the remaining days of the month in which the sixtieth day falls.~~
   ~~e.~~ ~~An eligible caretaker relative and an individual under the age of twenty-one but not including children in foster care, who qualify for and require medical services on the basis of insufficient income and assets, but who do not qualify as categorically needy.~~
   ~~f.~~ ~~A pregnant woman, whose pregnancy has been medically verified and who:~~
      ~~(1) Would be eligible as categorically needy except for income and assets;~~
      ~~(2) Qualify on the basis of financial eligibility; or~~
      ~~(3) Meet the nonfinancial and asset requirements of the medicaid program and whose family income is at or below one hundred thirty-three percent of the poverty level.~~
   ~~g.~~ ~~An eligible woman, who applied for medicaid during pregnancy, for sixty days after the day the pregnancy ends, and for the remaining days of the month in which the sixtieth day falls.~~
   ~~h.~~ ~~A child under the age of six who meets the nonfinancial and asset requirements of the medicaid program and whose family income is at or below one hundred thirty-three percent of the poverty level.~~

~~i. A child, age six through eighteen, who meets the nonfinancial and asset requirements of the medicaid program and whose family income is at or below one hundred percent of the poverty level.~~ The parents or caretaker relatives and their spouses of a deprived child under the age of eighteen years, but through the month of the child's eighteenth birthday, up to fifty-four percent of the federal poverty level.

b. For up to twelve months, the parents or caretaker relatives, along with their spouses and dependent children, of a deprived child under the age of eighteen years, but through the month of the child's eighteenth birthday, who were eligible under the parents and caretaker relatives and their spouses category in at least three of the six months immediately preceding the month in which the parents or caretakers lose coverage under the parents and caretaker relatives and their spouses category due to increased earned income or hours of employment.

c. For up to four months, the parents or caretaker relatives, along with their spouses and dependent children, of a deprived child under the age of eighteen years, but through the month of the child's eighteenth birthday, who were eligible under the parents and caretaker relative and their spouses category in at least three of the six months immediately preceding the month in which the parents or caretaker relatives lose coverage under the parents and caretaker relatives and their spouses category due to increased alimony or spousal support.

d. A pregnant woman up to one hundred forty-seven percent of the federal poverty level;

e. An eligible woman who applied for and was eligible for medicaid during pregnancy continues to be eligible for sixty days, beginning on the last day of pregnancy, and for the remaining days of the month in which the sixtieth day falls.

f. A child born to an eligible pregnant woman who applied for and was found eligible for medicaid on or before the day of the child's birth, for twelve months, beginning on the day of the child's birth and for the remaining days of the month in which the twelfth month falls.

g. A child, not including a child in foster care, from birth through five years of age up to one hundred forty-seven percent of the federal poverty level;

h. A child, not including a child in foster care, from six through eighteen years of age, up to one hundred thirty-three percent of the federal poverty level;

i. A child, not including a child in foster care, from six through eighteen years of age who becomes medicaid eligible due to an increase in the medicaid income levels used to determine eligibility.

j. An individual who is not otherwise eligible for medicaid and who was in title IV-E funded, state-funded, or tribal foster care in this

state under in the month the individual reaches eighteen years of age, through the month in which the individual reaches twenty-six years of age.

k. A pregnant woman who requires medical services and qualifies for medicaid on the basis of financial eligibility resulting in a recipient liability under section 75-02-02.1-41.1 and whose income is above one hundred forty-seven percent of the federal poverty level.

l. A child less than nineteen years of age who requires medical services and qualifies for medicaid on the basis of financial eligibility resulting in a recipient liability under section 75-02-02.1-41.1 and whose income is above one hundred seventy percent of the federal poverty level.

m. The parents and caretaker relatives and their spouses of a deprived child who require medical services and qualify for medicaid on the basis of financial eligibility resulting in a recipient liability under section 75-02-02.1-41.1 and whose income is above one hundred thirty-three percent of the federal poverty level.

3. A physician ~~or,~~ nurse practitioner, or physician assistant practicing in the following specialties, practices, or settings may be selected as a primary care provider:
   a. Family practice;
   b. Internal medicine;
   c. Obstetrics;
   d. Pediatrics;
   e. ~~Osteopathy;~~
   ~~f.~~ General practice;
   ~~g.~~ f. A rural health clinic;
   ~~h.~~ g. A federally qualified health center; or
   ~~i.~~ h. An Indian health ~~service~~ services clinic.
4. A recipient identified in subsection 2 need not select, or have selected on the recipient's behalf, a primary care provider if:
   a. The recipient is aged, blind, or disabled;
   b. The period for which benefits are sought is prior to the date of application;
   c. The recipient is receiving foster care or subsidized adoption benefits; ~~or~~
   d. The recipient is receiving home and community-based services; or
   e. The recipient has been determined medically frail under section 75-02-02.1-14.1.
5. Payment may be made for the following medically necessary covered services whether or not provided by, or upon referral from, a primary care provider:
   a. Early and periodic screening, diagnosis, and treatment of recipients under age twenty-one;
   b. Family planning services;
   c. Certified nurse midwife services;

d. Optometric services;
e. Chiropractic services;
f. Dental services;
g. Orthodontic services provided as the result of a referral through the early and periodic screening, diagnosis, and treatment program;
h. Services provided by an intermediate care facility for the intellectually disabled;
i. Emergency services;
j. Transportation services;
k. Targeted case management services;
l. Home and community-based services;
m. Nursing facility services;
n. Prescribed drugs except as otherwise specified in section 75-02-02-27;
o. Psychiatric services;
p. Ophthalmic services;
q. Obstetrical services;
r. Psychological services;
s. Ambulance services;
t. Immunizations;
u. Independent laboratory and radiology services;
v. Public health unit services; and
w. Personal care services.

6. Except as provided in subsection 4, or unless the department exempts the recipient, a primary care provider must be selected for each recipient.
7. A primary care provider may be changed during the ninety days after the recipient's initial enrollment with the primary care provider or the date the state sends the recipient notice of the enrollment, at redetermination of eligibility, once every ~~six~~ twelve months during the open enrollment period, or with good cause. Good cause for changing a primary care provider less than ~~six~~ twelve months after the previous selection of a primary care provider exists if:
   a. The recipient relocates;
   b. Significant changes in the recipient's health require the selection of a primary care provider with a different specialty;
   c. The primary care provider relocates or is reassigned;
   d. The selected provider refuses to act as a primary care provider or refuses to continue to act as a primary care provider; or
   e. The department, or its agents, determines that a change of primary care provider is necessary.

History: Effective October 1, 2012; amended effective July 1, 2014; April 1, 2016.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-32; 42 USC 1396u-2

SECTION 13. Subdivision e of subsection 1 of section 75-02-02.1-24 is amended as follows:

75-02-02.1-24. Spousal impoverishment prevention.

1. For purposes of this section:

   e. "Monthly maintenance needs allowance" means for a community spouse, the greater of ~~two thousand two hundred sixty-seven dollars~~ the amount authorized by the legislative assembly per month or the minimum amount permitted under section 1924(d)(3) of the Act [42 U.S.C. 1396r-5(d)(3)], as adjusted pursuant to section 1924(g) of the Act [42 U.S.C. 1396r-5(g)]..

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; October 1, 1993; July 1, 2003; June 1, 2004; May 1, 2006; April 1, 2008; January 1, 2011; April 1, 2016.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396r-5