CHAPTER 75-02-05
PROVIDER INTEGRITY

SECTION 1. Section 75-02-05-01 is amended as follows:

75-02-05-01. Purpose. The purpose underlying administrative remedies and sanctions in the medical assistance (medicaid) program is to ~~assure~~ ensure the proper and efficient utilization of medicaid funds by those individuals providing medical~~, dental,~~ and other health services and goods to recipients of ~~public~~ medical assistance ~~and medically indigent persons~~.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-01

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

75-02-05-02. Authority and objective. Under authority of North Dakota Century Code chapter 50-24.1, the department of human services is empowered to promulgate ~~such~~ rules and regulations ~~as are~~ necessary to qualify for federal funds under section 1901 specifically, and title XIX generally of the Social Security Act. These ~~regulations~~ rules are subject to the medical assistance state plan and to applicable federal regulation and state law ~~and regulation~~.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-06-05.1, 50-24.1-04
Law Implemented: NDCC 50-24.1-04

SECTION 3. 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;

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 ~~division of medical services~~ department.

~~2.~~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.

~~3.~~5. "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.

6. "Closed-end medicaid provider agreement" means an agreement that is for a specified period of time not to exceed twelve months.

~~4.~~7. "Credible allegation of fraud" means an allegation which has been verified by the department.

8. "Department" means the department of human services.

9. "Division" means the medical services division of the department.

10. "Exclusion from participation" means permanent removal from provider participation in the North Dakota medical assistance program.

11. "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.

12. "Licensed practitioner" means an individual, other than a physician who is licensed pursuant to North Dakota century code chapter 43-17, or otherwise authorized by the state to provide health care services.

~~5.~~13. "Medicaid" means "medical assistance" and is a term precisely equivalent thereto.

~~6.~~14. "Offsetting of payments" means a reduction or other adjustment of the amounts paid to a provider on pending and future bills for purposes of offsetting overpayments previously made to the provider.

~~7.~~15. "Open-end medicaid provider agreement" means an agreement that has no specific termination date and continues in force as long as it is agreeable to both parties.

~~8.~~16. "Person" means any natural person, company, firm, association, corporation, or other legal entity.

~~9.~~17. "Provider" means any individual or entity furnishing medicaid services under a provider agreement with the division of medical services.

~~10.~~18. "Sanction" means an action taken by the division against a provider for noncompliance with a federal or state law, rule, or policy, or with the provisions of the North Dakota medicaid provider agreement.

19. "Suspension from participation" means temporary suspension of provider participation in the North Dakota ~~medical assistance~~ medicaid program for a specified period of time.

~~11.~~20. "Suspension of payments" means the withholding of payments due a provider until ~~the resolution of~~ the matter in dispute between the provider and the division ~~of medical services~~ is resolved.

21. "Termination" means determining a provider to be indefinitely ineligible to be a medicaid provider.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: ~~42 CFR 431.1~~,42 CFR 431.107

SECTION 4. Section 75-02-05-04 is amended as follows:

75-02-05-04. Provider responsibility. ~~In order to~~ To assure ~~the highest~~ quality medical care and services, medicaid payments ~~shall~~ may be made only to providers meeting established standards. Providers who are certified for participation in medicare ~~shall be automatically approved~~ 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 is limited to those services ~~certified as~~ that are medically necessary ~~in the judgment of a qualified physician or other practitioner,~~ 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. ~~Providers agree~~ Each provider agrees to ~~keep~~ 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 ~~division of medical services~~ department and the United States department of health and human services~~, such~~ A provider shall provide the records ~~as they may, from time to time, deem necessary and proper~~ at no charge.
3. A provider must accept, as payment in full, the amounts paid in accordance with the payment structure established ~~for medicaid~~ by the department. A provider performing a procedure or service may not request or receive any payment, in addition to ~~such~~ the amounts established ~~amounts~~ by the department, from the recipient, or anyone acting on the recipient's behalf, for the same procedure or service. In cases where a ~~recipient liability~~ client share has been properly determined by a county social service board, the provider may hold the recipient responsible for a ~~portion of~~ the ~~allowable fee~~ client share.

4. No medicaid payment will be made for claims received by the ~~division of medical services~~ department later than twelve months following the date the service was provided ~~except that any periods of time exceeding thirty days, from the time a provider requests an authorization to the time the authorization is sent to the provider, shall be added to the twelve months~~.
5. The department will process claims six months past the medicare explanation of benefits date if the provider followed medicare's timely filing policy.
6. In all joint medicare/medicaid cases, a provider ~~of service~~ must accept assignment of medicare payment ~~in order~~ to receive payment from medicaid for amounts not covered by medicare.
~~6.~~7. When the recipient has other medical insurance, all benefits available due ~~to such~~ from that other insurance must be applied prior to the ~~acceptance of~~ provider accepting payment by medicaid.
~~7.~~8. ~~Providers~~ A provider may not offer or accept a fee, portion of a fee, charge, rebate, or kickback for a medicaid patient referral.
~~8.~~9. Claims for payment and documentation ~~as required~~ must be submitted ~~on forms prescribed~~ as required by the ~~division of medical services~~ department or its designee.
~~9.~~10. A provider ~~must~~ shall comply with all accepted standards of professional conduct and practice in dealing with recipients and the ~~division of medical services~~ department.
11. A provider may not bill a recipient for services that are allowable under medicaid, but not paid due to the provider's lack of adherence to medicaid requirements.
12. Each provider shall comply with all applicable centers for medicare and medicaid services regulations.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 431.107

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

75-02-05-05. Grounds for sanctioning providers. Sanctions may be imposed by the division ~~of medical services~~ against a provider who:

1. Presents or causes to be presented for payment any false or fraudulent claim for care or services.
2. Submits or causes to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.
3. Submits or causes to be submitted false information for the purpose of meeting prior authorization requirements.
4. Submits a false or fraudulent application to obtain provider status.
5. Fails to disclose or make available to the ~~division of medical services~~ department or its authorized agent records of services provided to medicaid recipients and records of payments received for those services.

6. Fails to provide and maintain services to medicaid recipients within accepted medical ~~community~~ and industry standards ~~as adjudged by a body of peers~~.
7. Fails to comply with the terms of the medicaid provider agreement or provider certification ~~agreement~~ which is printed on the medicaid claim form.
8. Overutilizes the medicaid program by inducing, furnishing, or otherwise causing a recipient to receive care and services that are not ~~required by the recipient~~ medically necessary.
9. Rebates or accepts a fee or portion of a fee or charge for a medicaid patient referral.
10. Is convicted of a criminal offense arising out of the practice of medicine ~~in a manner which resulted in death or injury to a patient~~.
11. Fails to comply and to maintain compliance with all regulations and statutes, both state and federal, which are applicable to the ~~applicant's/licensee's~~ provider's profession, business, or enterprise.
12. Is ~~suspended or involuntarily terminated~~ excluded from ~~participation in~~ medicare.
13. Is suspended, excluded from participation, terminated, or sanctioned by any other state's medicaid program.

~~13.~~14. Is suspended or involuntarily terminated from participation in any governmentally sponsored medical program ~~such as workmen's compensation, crippled children's services, rehabilitation services, and medicare~~.

~~14.~~15. Bills or collects from the recipient any amount in violation of section 75-02-05-04.

~~15.~~16. Fails to correct deficient provider operations within a reasonable time, not to exceed thirty days, after receiving written notice of these deficiencies from the division ~~of medical services~~, ~~other~~ another responsible state ~~agencies~~ agency, or their designees.

~~16.~~17. Is formally reprimanded or censured by an association of the provider's peers for unethical practices.

~~17.~~18. Fails to change or modify delivery patterns and services within a reasonable period after receipt of a request so to do by a peer review committee whose jurisdiction includes the provider.

~~18.~~19. Is convicted of a criminal offense arising out of the making of false or fraudulent statements or of an omission of fact for the purpose of securing any governmental benefit to which the provider is not entitled, or out of conspiring, soliciting, or attempting such an action.

~~19.~~20. Refuses to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments. A refusal of repayment exists if no repayment or arrangement for repayment is made within thirty days of the date written notice of discrepancy was sent.

~~20.~~21. Is served with a search warrant by a member of any law enforcement agency for the purpose of obtaining evidence of a crime of fraud committed~~,~~ by that provider~~,~~ against the medical assistance program, or is

charged with such a crime, provided that no provider may be terminated from participation in the medical assistance program on such grounds.

22. Refuses to attend a division educational program or fails to agree to implement a business integrity agreement, if required by the division.

23. Defrauds any health care benefit program.

History: Effective July 1, 1980; amended effective November 1, 1983; July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 12.1-11-02; ~~42 CFR 455.11,~~ 42 CFR 455.13, 42 CFR 455.16, 42 CFR 431.107

SECTION 6. Section 75-02-05-06 is amended as follows:

75-02-05-06. Reporting of violations and investigation.

1. Information from any source indicating that a provider has failed or is failing to fulfill the provider's responsibilities, as set forth in section 75-02-05-04; or that a provider has acted ~~or omitted to act~~ in a manner which forms a ground for sanction as set forth in section 75-02-05-05 ~~shall~~ must be transmitted to the division ~~of medical services~~.

2. The division shall ~~forthwith~~ investigate the matter and, ~~should~~ if the report ~~be~~ is substantiated, shall take whatever action or impose whatever sanction is ~~deemed~~ most appropriate. The taking of any action or the imposition of any sanction ~~shall~~ does not preclude subsequent or simultaneous civil or criminal court action.

3. a. The division may investigate suspected fraud or abuse. The division may conduct an investigation to determine whether:
   (1) Fraud or abuse exists and can be substantiated;
   (2) Sufficient evidence exists to support the recovery of overpayments, or the imposition of sanctions; or;
   (3) The matter should be referred for action by another agency, including a law enforcement agency to determine whether sufficient evidence exists to pursue any other civil or criminal action permitted by law.

   b. The division may undertake an investigation to:
   (1) Examine a provider's medical, financial, or patient records;
   (2) Interview a provider and a provider's associates, agents, or employees;
   (3) Verify a provider's professional credentials, and the credentials of the provider's associates, agents, and employees;
   (4) Interview recipients;
   (5) Examine equipment, prescriptions, supplies, or other items used in a recipient's treatment;
   (6) Sample a random mix of paid claims, prior authorizations, and medical records;
   (7) Determine whether services provided to a recipient were medically necessary;

(8) Examine insurance claims or records, or records of any other source of payment, including recipient payments; or

(9) The division may refer the case to the appropriate authority for further investigation and prosecution.

4. The division may contract with specialists outside the department as part of the investigation.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 455.14, 42 CFR 455.15, 42 CFR 455.16

SECTION 7. Section 75-02-05-07 is amended as follows:

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

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

~~a.~~(1) The nature of the discrepancy or inconsistency.

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

~~c.~~(3) The method of computing such dollar values.

~~d.~~(4) Further actions which the division may take.

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

~~2.~~b. When the division ~~of medical services~~ has notified the provider in writing of a discrepancy or inconsistency, it may withhold payments on pending and future claims ~~in an amount reasonably calculated to approximate the amounts in question pending~~ awaiting a response from the provider. ~~If the division of medical services and the provider are able to satisfactorily resolve the matter, sanctions shall not be imposed.~~

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 division may require the provider to participate in and complete an educational program.

a. If the division decides that a provider should participate in an educational program, the division 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 division; and

(3) That continued participation as a provider in medicaid is contingent upon completion of the education program identified by the division.

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 program;
   (6) Education on reimbursement rates and payment methodologies;
   (7) Instructions on billing or submitting claims; and
   (8) Other educational tools identified by the division.

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 until the provider successfully completes the required program. The timeframe 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 division of medical services 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 until the provider implements the required agreement.

5. The division shall suspend all medicaid payments to a provider after the division determines there is a credible allegation of fraud for which an investigation is pending under the medicaid program unless the provider has demonstrated good cause why the division should not suspend payments or should suspend payment only in part.

6. The director of the 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. When a provider has been excluded from the medicare program, the provider will also be terminated or excluded from participation.

8. 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. Pre payment review of claims;
   b. Post payment 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 program and withholding of payments to a provider;
   g. Prior authorization of all services; and
   h. Peer review at the provider's expense.
9. After the completion of a further investigation, the division shall document its findings in writing and provide a copy of that documentation to the provider. Following a determination by the division that the provider has engaged in fraud or abuse; the division 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. Pre payment review of claims;
   f. Post payment 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. 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. 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 or its fiscal agent for any services or supplies provided under the medicaid program except for any services or supplies provided prior to the effective date of the termination or exclusion.
12. 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. When the division determines there is a need to sanction a provider, the director of the 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 of appeal, when applicable.
14. After the division sanctions a provider, the director of the division may notify the applicable professional society, board of registration or licensure, and any appropriate federal, state, or county agency of the reasons for the sanctions and the sanctions imposed.
15. 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.
General Authority: NDCC 50-24.1 04
Law Implemented: NDCC 50-24.1.-04; 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 8. Section 75-02-05-08 is repealed.

~~**75-02-05-08. Imposition and extent of sanction.**~~

~~1. **Imposition of sanction.**~~

~~a. The determination of appropriate sanction shall be at the discretion of the director of the division of medical services or the director's designee.~~

~~b. The following factors shall be considered in determining the sanction to be imposed:~~

~~(1) Seriousness of the offense.~~
~~(2) Extent of the violations.~~
~~(3) History of prior violations.~~
~~(4) Prior imposition of sanctions.~~
~~(5) Prior provision of provider information and training.~~
~~(6) Provider willingness to adhere to program rules.~~
~~(7) Agreement to make restitution.~~
~~(8) Actions taken or recommended by peer groups or licensing boards.~~

~~c. When a provider has been suspended or involuntarily terminated from the medicare program, the director of the division of medical services or the director's designee shall impose the same sanction as that imposed by medicare.~~

~~d. A provider convicted of a violation of North Dakota Century Code section 12.1-24-03 shall be suspended from further participation in the medicaid program for a period of at least thirty days, or shall be terminated from participation in the medicaid program.~~

~~2. **Scope of sanction.**~~

a. One or more of the following sanctions may be imposed on providers who become subject to sanction:
   (1) Termination from participation in the medicaid program.
   (2) Suspension from participation in the medicaid program.
   (3) Suspension or withholding of payments to a provider.
   (4) Transfer to a closed-end provider agreement not to exceed twelve months.
   (5) Mandatory attendance at provider information sessions.
   (6) Prior authorization of services.
   (7) One hundred percent review of the provider's claims prior to payment.
   (8) Referral to the state licensing board or other appropriate body for investigation.
   (9) Referral to peer review.

b. A sanction may be applied to all known affiliates of a provider, provided that each affiliate so sanctioned knew or should have known, had the affiliate properly carried out the affiliate's official duties, of the violation, failure or inadequacy of performance for which the sanction is imposed.

c. No provider who is subject to suspension or termination from participation shall submit claims for payment, either personally or through claim submitted by any clinic, group, corporation, or other association to the division of medical services or its fiscal agent for any services or supplies provided under the medicaid program except for any services or supplies provided prior to the effective date of the suspension or termination.

d. No clinic, group, corporation, or other organization which is a provider of services shall submit claims for payment to the division of medical services or its fiscal agent 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 and supplies provided prior to the effective date of the suspension or termination.

e. Claims submitted in violation of subdivisions c and d will be returned without processing. The submission of such claims may subject the person or organization submitting to sanction.

3. **Notice of sanction.**

a. When a provider has been sanctioned, the director of the division of medical services or the director's designee shall notify the provider in writing of the sanction imposed. Such notice will also advise the provider of the right of appeal.

b. When a provider has been sanctioned, the director of the division of medical services may notify, as appropriate, the applicable professional society, board of registration or licensure, and federal, state, or county agencies of the findings made and the sanctions imposed.

~~c. When a provider's participation in the medicaid program has been suspended or terminated, the director of the division of medical services or the director's designee will notify the counties from whom the provider has requested claims for services, that such provider has been suspended or terminated. Each county agency so notified shall post, in a prominent place within its office, the name and location of the suspended or terminated provider. The posting shall remain in place for the entire period of a suspension, and for the first ninety days of a termination.~~

History: Effective July 1, 1980; repealed effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 455.16(c)

SECTION 9. Section 75-02-05-09 is amended as follows:

75-02-05-09. Appeal and reconsideration.

1. A provider may not appeal a temporary sanction until further investigation has been completed and the division has made a final decision.
2. ~~Within thirty days after notice of sanction~~After completion of further investigation, if there is an imposition of a subsequent sanction, the provider may appeal the decision to impose sanctions ~~to the department of human services~~ unless the sanction imposed is termination or suspension and the notice states that the basis for ~~such~~ the sanction is:
   a. The provider's failure to meet standards of licensure, certification, or registration where those standards are imposed by state or federal law as a condition to participation in the medicaid program.
   b. Because the provider has been similarly sanctioned by the medicare program or by another state's medicaid program.

~~2.~~3. An appeal must be filed with the department within thirty days of the date the notice of sanction is mailed to the provider.

4. Appeals taken ~~shall be~~ are governed by chapter 75-01-03, and providers ~~shall~~ will be treated as claimants ~~thereunder~~ under that chapter.

~~3.~~5. Without prejudice to any right of appeal, the provider, upon receipt of notice of ~~sanction,~~decision may in writing, request reconsideration. ~~Such~~ The request for reconsideration must include a statement refuting the stated basis for the imposition of the sanction. The division ~~of medical services~~ shall, within ten days after receipt of a request for reconsideration, make written response to the request, stating that imposition of the sanction has been affirmed or reversed.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 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; NDAC 75-01-03; 42 USC 1396a(a)(39); 42 CFR 431.151; 42 CFR 455.13

SECTION 10. Section 75-02-05-10 is repealed.

~~**75-02-05-10. Provider information sessions.**~~

~~1. Except where termination has been imposed, each provider who has been sanctioned shall participate in a provider education program as a condition of continued participation, if the division of medical services in its direction so directs.~~

~~2. Provider education programs may include any of the following topics, or may include other topics that are deemed by the division of medical services to be reasonable and necessary:~~

~~a. Instruction in claim form completion.~~

~~b. Instruction on the use and format of provider manuals.~~

~~c. Instruction on the use of procedure codes.~~

~~d. Instruction on statutes, rules, and regulations governing the North Dakota medicaid program.~~

~~e. Instruction on reimbursement rates.~~

~~f. Instructions on how to inquire about coding or billing problems.~~

~~g. Any other matter as determined by the division of medical services.~~

History: Effective July 1, 1980; repealed effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 455.16(c)

north dakota
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February 29, 2012

RE: Proposed Amendments to N.D. Admin. Code Chapter 75-02-05
Provider Integrity

TO WHOM IT MAY CONCERN:

The Department of Human Services is proposing amendments to N.D. Admin. Code chapter 75-02-05, Provider Integrity. The department has adopted procedures to assure public input into the formulation of such rules prior to adoption.

In conformity with those procedures, we are providing you with a copy of the proposed rules and are requesting that you provide any written data, views, or arguments no later than 5:00 p.m. on Friday, April 13, 2012.

The department has scheduled an oral hearing on Tuesday, April 3, 2012. Further information concerning the public hearing is included in the attached notice of proposed rulemaking and public hearing.

Your participation is welcomed, as are your suggestions. Please send all written data, views, or arguments to: Rules Administrator, Department of Human Services, State Capitol - Judicial Wing, 600 E. Boulevard Ave., Bismarck, ND 58505-0250.

Sincerely,

Carol K. Olson

Carol K. Olson,
Executive Director

CKO/kh

Attachments

Cc: John Walstad, Legislative Council
Cindy Sheldon, Medical Services