CHAPTER 75-02-02
MEDICAL SERVICES

75-02-02-30 Primary Care Provider

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 ~~applications are~~ is a determination of the medical necessity of the proposed services as required for all ~~residential treatment center~~ applicants or recipients ~~of~~ under the age of twenty-one prior to admission to a psychiatric hospital ~~or~~, an inpatient psychiatric program in a hospital ~~and~~, or a psychiatric facility, including a psychiatric residential treatment ~~centers to determine the medical necessity of the proposed services~~ facility. The certification of need evaluates the ~~recipient's~~ 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.

~~7.~~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.

~~8.~~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.

~~9.~~11. "Recipient" means an individual approved as eligible for medical assistance.

~~10.~~12. "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.

~~11.~~13. "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.

~~12. "Residential treatment center for children" means a facility or a distinct part of a facility that provides to children and adolescents a total, twenty-four-hour, therapeutic environment integrating group living, educational services, and a clinical program based upon a comprehensive, interdisciplinary clinical assessment and an individualized treatment plan that meets the needs of the child and family. The services are available to children in need of and able to respond to active psychotherapeutic intervention and who cannot be effectively treated in their own family, in another home, or in a less restrictive setting.~~

~~13. "Secretary" means the secretary of the United States department of health and human services.~~

14. "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; July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-01

SECTION 2. 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 ~~for medical assistance~~ in effect at the time the service is rendered by providers. ~~and which~~ Services may include:
   a. (1) Inpatient hospital services ~~(other than services in an institution for mental diseases)~~. "Inpatient hospital services"

means those items and services ordinarily furnished by the hospital for the care and treatment of inpatients provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases and which is licensed or formally approved as a hospital by an officially designated state standard-setting authority and is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation; and which has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under title XIX of the Act.

(2) Inpatient prospective payment system hospitals that are reimbursed by a diagnostic-related group will follow medicare guidelines for supplies and services included and excluded as outlined in 42 C.F.R. 409.10.

b. Outpatient hospital services. "Outpatient hospital services" means those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to an outpatient by an institution which is licensed or formally approved as a hospital by an officially designated state standard-setting authority and is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation and emergency hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available which is equipped to furnish such services, even though the hospital does not currently meet the conditions for participation under title XVIII of the Social Security Act.

c. Other laboratory and x-ray services. "Other laboratory and x-ray services" means professional and technical laboratory and radiological services ordered by a 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, and provided to a patient by, or under the direction of, a physician or licensed practitioner, in an office or similar facility other than a hospital outpatient department or a clinic, and provided to a patient by a laboratory that is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.

d. Nursing facility services ~~(other than services in an institution for mental diseases)~~. "Nursing facility services" does not include services in an institution for mental diseases and means those items and services furnished by a licensed and otherwise eligible

nursing facility or swing-bed hospital maintained primarily for the care and treatment which are provided under the direction of a 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 individuals who need or needed on a daily basis nursing care, provided directly or requiring the supervision of nursing personnel, or other rehabilitation services which, as a practical matter, may only be provided in a nursing facility on an inpatient basis.

e. Intermediate care facility for the mentally retarded services. "Intermediate care" means those items and services which are provided under the direction of a 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. "Intermediate care facility for the mentally retarded" has the same meaning as provided in chapter 75-04-01.

f. Early and periodic screening and diagnosis of individuals under twenty-one years of age and treatment of conditions found. Early and periodic screening and diagnosis of individuals under the age of twenty-one who are eligible under the plan to ascertain their physical or mental defects, and provide health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Federal financial participation is available for any item of medical or remedial care and services included under this subsection for individuals under the age of twenty-one. Such care and services may be provided under the plan to individuals under the age of twenty-one, even if such care and services are not provided, or are provided in lesser amount, duration, or scope to individuals twenty-one years of age or older.

g. Physician's services~~, whether furnished in the office, the patient's home, a hospital, nursing facility, or elsewhere~~. "Physician's services" whether furnished in the office, the patient's home, a hospital, nursing facility, or elsewhere means those services provided, within the scope of practice of the physician's profession as defined by state law, by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy.

h. Medical care and any other type of remedial care other than physician services recognized under state law~~,~~ and furnished by licensed practitioners within the scope of their practice as defined by state law. ~~This term means any medical or remedial care or services other than physicians' services, provided within the scope of practice as defined by state law, by an individual licensed as a practitioner under state law.~~

i. Home health care services.~~-~~"Home health care services", is in addition to the services of physicians, dentists, physical therapists,

and other services and items available to patients in their homes and described elsewhere in ~~these definitions~~ this section, means any of the following items and services when they are provided, based on certification of need and a written plan of care by a licensed physician, to a patient in the patient's place of residence, ~~but not including as~~ excluding a residence that is a hospital or a skilled nursing facility:

(1) Intermittent or part-time skilled nursing services furnished by a home health agency;

(2) Intermittent or part-time nursing services of a registered nurse, or a licensed practical nurse, or which are provided under the direction of a 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~~ ~~or~~ and under the supervision of a registered nurse, when ~~no~~ a home health agency is not available to provide nursing services;

(3) Medical supplies, equipment, and appliances ordered or prescribed by the physician as required in the care of the patient and suitable for use in the home; and

(4) Services of a home health aide provided to a patient in accordance with the plan of treatment outlined for the patient by the attending physician and in collaboration with the home health agency.

j. Hospice care. "Hospice care" means the care described in 42 U.S.C. 1395x(dd)(1) furnished by a "hospice program", as that term is defined in 42 U.S.C. 1395x(dd)(2), to a terminally ill individual who has voluntarily elected to have hospice care. Hospice care may be provided to an individual while the individual is a resident of a nursing facility, but only the hospice care payment may be made. An individual's voluntary election must be made in accordance with procedures established by the department which are consistent with procedures established under 42 U.S.C. 1395d(d)(2), for such periods of time as the department may establish, and may be revoked at any time.

k. Private duty nursing services. "Private duty nursing services" means nursing services provided, based on certification of need and a written plan of care which is provided under the direction of a 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~~, ~~and~~ by a registered nurse or a licensed practical nurse under the supervision of a registered nurse to a patient in the patient's own home.

l. Dental services. "Dental services" means any diagnostic, preventive, or corrective procedures administered by or under the supervision of a dentist in the practice of the dentist's profession

and not excluded from coverage. Dental services include treatment of the teeth and associated structures of the oral cavity, and of disease, injury, or impairment which may affect the oral or general health of the individual.

m. Physical therapy.-"Physical therapy" means those services prescribed by a physician and provided to a patient by or under the supervision of a qualified physical therapist.

n. Occupational therapy. "Occupational therapy" means those services prescribed by a physician and provided to a patient and given by or under the supervision of a qualified occupational therapist.

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.

p. Prescribed drugs. "Prescribed drugs" means any simple or compounded substance or mixture of substances prescribed as such or in other acceptable dosage forms for the cure, mitigation, or prevention of disease, or for health maintenance, by a physician or other licensed practitioner of the healing arts within the scope of the physician's or practitioner's professional practice as defined and limited by federal and state law.

q. Durable medical equipment and supplies. "Durable medical equipment and supplies" means those medically necessary items suitable for use in the home and used to treat disease, to promote healing, to restore bodily functioning to as near normal as possible, or to prevent further deterioration, debilitation, or injury which are provided under the direction of a 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. Durable medical equipment includes prosthetic and orthotic devices, eyeglasses, and hearing aids. For purposes of this subdivision:

(1) "Eyeglasses" means lenses, including frames when necessary, and other aids to vision prescribed by a physician skilled in diseases of the eye, or by an optometrist, whichever the patient may select, to aid or improve vision;

(2) "Hearing aid" means a specialized orthotic device individually prescribed and fitted to correct or ameliorate a hearing disorder; and

(3) "Prosthetic and orthotic devices" means replacement, corrective, or supportive devices prescribed for a patient by a 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 artificially replacing a missing portion of the body, or to prevent or correct physical deformity or malfunction, or to support a weak or deformed portion of the body.

r. Other diagnostic, screening, preventive, and rehabilitative services.

(1) "Diagnostic services", other than those for which provision is made elsewhere in these definitions, includes any medical procedures or supplies recommended 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, as necessary to enable the physician or practitioner to identify the existence, nature, or extent of illness, injury, or other health deviation in the patient.

(2) "Preventive services" means those provided by a 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, to prevent illness, disease, disability, and other health deviations or their progression, prolong life, and promote physical and mental health and efficiency.

(3) "Rehabilitative services", in addition to those for which provision is made elsewhere in these definitions, includes 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.

(4) "Screening services" consists of the use of standardized tests performed under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify suspects for more definitive studies.

s. Inpatient psychiatric services for individuals under age twenty-one, as defined in 42 CFR 440.160, provided consistent with the requirements of 42 CFR part 441 and section 75-02-02-10.

t. Services provided to persons age sixty-five and older in an institution for mental diseases, as defined in 42 U.S.C. 1396d(i).

u. Personal care services. "Personal care services" means those services that assist an individual with activities of daily living and instrumental activities of daily living ~~in order~~ to maintain independence and self-reliance to the greatest degree possible.

v. Any other medical care and any other type of remedial care recognized under state law and specified by the secretary <u>of the United States' department of health and human services</u>, including:

(1) Transportation, including expenses for transportation and other related travel expenses, necessary to securing medical examinations or treatment when determined by the department to be medically necessary.

(2) Family planning services, including drugs, supplies, and devices, when such services are under the medical direction of a physician. There must be freedom from coercion or pressure of mind and conscience and freedom of choice of method, so that individuals may choose in accordance with the dictates of their consciences.

(3) Whole blood, including items and services required in collection, storage, and administration, when it has been recommended by a physician or licensed practitioner and when it is not available to the patient from other sources.

w. An exercise program. "Exercise program" includes exercise regimens to achieve various improvements in physical fitness and health.

x. A weight loss program. "Weight loss program" includes programs designed for reduction in weight, but does not include weight loss surgery.

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

a. Coverage may not be extended and payment may not be made for ~~diet remedies~~ an exercise program or a weight loss program prescribed for eligible recipients.

b. Coverage may not be extended and payment may not be made for alcoholic beverages prescribed for eligible recipients.

c. Coverage may not be extended and payment may not be made for orthodontia prescribed for eligible recipients, except for orthodontia necessary to correct serious functional problems.

d. Coverage may not be extended and payment may not be made for any service provided to increase fertility or to evaluate or treat fertility.

e. Coverage and payment for eye examinations and eyeglasses for eligible recipients are limited to, and payment will only be made for, examinations and eyeglass replacements necessitated because of visual impairment. ~~Coverage and payment for eyeglass frames are available for a reasonable number of frames, and in a reasonable amount, not to exceed limits set by the department. No coverage exists, and no payment may be made, for eyeglass frames which exceed the limits.~~

~~e.~~f. Coverage may not be extended to and payment may not be made for any physician-administered drugs in an outpatient setting if the drug does not meet the requirements for a covered outpatient drug as outlined in section 1927 of the social security act (42 U.S.C. 1396r-8).

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.

(1) This limit may be exceeded, in unusual and complex cases, if the provider has submitted and the department has approved a prior treatment authorization request ~~describing each medical and remedial service to be received by the recipient, stating the cost of that service, describing~~.

(2) The prior authorization request must describe the medical necessity ~~for the provision~~ of the home health care services or private duty nursing services, and ~~explaining~~ explain why less costly alternative treatment does not afford necessary medical care~~, and has had the request approved~~.

~~f.~~h. Coverage may not be extended and payment may not be made for transportation services except as provided in sections 75-02-02-13.1 and 75-02-02-13.2.

~~g.~~i. Coverage may not be extended and payment may not be made for any abortion except when necessary to save the life of the mother or when the pregnancy is the result of an act of rape or incest.

~~h.~~j. Coverage for ambulance services must be in response to a medical emergency and may not be extended and payment may not be made for ambulance services that are not medically necessary, as determined by the department~~, and provided in response to a medical emergency~~.

~~i.~~k. Coverage for an emergency room must be made in response to a medical emergency and may not be extended and payment may not be made for emergency room services that are not medically necessary, as determined by the department under section 75-02-02-12~~, and provided in response to a medical emergency~~.

~~j.~~l. Coverage may not be extended and payment may not be made for medically necessary chiropractic services exceeding ~~twenty-four~~ twelve treatments for spinal manipulation services and ~~eight~~ two radiologic examinations per year, per recipient, unless the provider requests and receives prior authorization from the department.

~~k.~~m. Coverage and payment for personal care services:

(1) May not be made unless prior authorization is granted, and the recipient meets the criteria established in subsection 1 of section 75-02-02-09.5; and

(2) May be approved for:

(a) Up to one hundred twenty hours per month, or at a daily rate;

(b) Up to two hundred forty hours per month if the recipient meets the medical necessity criteria for nursing facility level of care described in section 75-02-02-09 or intermediate care facility for the mentally retarded level of care; or

(c) ~~May be approved up~~ Up to three hundred hours per month if the recipient is determined to be impaired in at least five of the activities of daily living of bathing, dressing, eating, incontinence, mobility, toileting, and transferring; meets the medical necessity criteria for nursing facility level of care described in section 75-02-02-09 or intermediate care facility for the mentally retarded level of care; and none of the three hundred hours approved for personal care services are allocated to the tasks of laundry, shopping, or housekeeping.

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 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.

3. a. Except as provided in subdivision b, remedial services are covered services.

b. Remedial services provided by residential facilities such as licensed basic care facilities, licensed foster care homes or facilities, and specialized facilities are not covered services, but expenses incurred in securing such services must be deducted from countable income in determining financial eligibility.

4. a. The department may refuse payment for any covered service or procedure for which a prior treatment authorization request is required but not secured.

b. The department may consider making payment if the provider demonstrates good cause for the failure to secure the required prior treatment authorization request. Provider requests for good cause consideration must be received within twelve months of the ~~time~~ date the services or procedures were furnished.

c. The department may refuse payment for any covered service or procedure provided to an individual eligible for both medicaid and other insurance if the insurance denies payment because of the failure of the provider or recipient to comply with the requirements of the other insurance.

5. A provider of medical services who provides a covered service except for personal care services, but fails to receive payment due to the ~~operation~~ requirements of subsection 4, and who attempts to collect from the eligible recipient or the eligible recipient's responsible relatives any amounts which would have been paid by the department but for the ~~operation~~ requirements of subsection 4, has by so doing breached the agreement referred to in subsection 4 of section 75-02-02-10.

~~6. a. Effective January 1, 1994, and for so long thereafter as the department may have in effect a waiver (issued pursuant to 42 U.S.C. 1396n(b)(1)) of requirements imposed pursuant to 42 U.S.C. chapter 7, subchapter XIX, no payment may be made, except as provided in this subsection, for otherwise covered services provided to otherwise eligible recipients:~~

~~(1) Who are required by this subsection to select, or have selected on their behalf, a primary care physician, but who have not selected, or have not had selected on their behalf, a primary care physician; or~~

~~(2) By a provider who is not the primary care physician selected by or on behalf of the recipient or who has not received a referral of such a recipient from the primary care physician.~~

~~b. A primary care physician must be selected by or on behalf of the members of a medical assistance unit which includes:~~

~~(1) Persons who are members of the section 1931 group.~~

~~(2) Families who were in the section 1931 group in at least three of the six months immediately preceding the month in which they became ineligible as a result (wholly or partly) of the collection or increased collection of child or spousal support, and continue to be eligible for medicaid for four calendar~~

~~months following the last month of section 1931 group eligibility.~~

~~(3) Families who were 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 which became ineligible because a member of the family lost the time-limited disregards (the percentage disregard of earned income).~~

~~(4) Children born to eligible pregnant women who have 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.~~

~~(5) Eligible caretaker relatives and individuals under the age of twenty-one who qualify for and require medical services on the basis of insufficient income and assets, but who do not qualify as categorically needy, but not including children in foster care.~~

~~(6) Pregnant women whose pregnancies have been medically verified and who, except for income and assets, would be eligible as categorically needy.~~

~~(7) Pregnant women whose pregnancies have been medically verified and who qualify on the basis of financial eligibility.~~

~~(8) Pregnant women whose pregnancies have been medically verified and who meet the nonfinancial and asset requirements of the medicaid program and whose family incomes are at or below one hundred thirty-three percent of the poverty level.~~

~~(9) Eligible women, who applied for medicaid during pregnancy, for sixty days after the day each pregnancy ends, and for the remaining days of the month in which the sixtieth day falls.~~

~~(10) Children under the age of six who meet the nonfinancial and asset requirements of the medicaid program and whose family incomes are at or below one hundred thirty-three percent of the poverty level.~~

~~(11) Children, age six through eighteen, who meet the nonfinancial and asset requirements of the medicaid program and whose family incomes are at or below one hundred percent of the poverty level.~~

~~c. Physicians practicing in the following specialties, practices, or locations may be selected as primary care physicians:~~

~~(1) Family practice;~~

~~(2) Internal medicine;~~

~~(3) Obstetrics;~~

~~(4) Pediatrics;~~

~~(5) Osteopathy;~~
~~(6) General practice;~~
~~(7) Rural health clinics;~~
~~(8) Federally qualified health centers; and~~
~~(9) Indian health clinics.~~

~~d. A recipient identified in subdivision b need not select, or have selected on the recipient's behalf, a primary care physician if:~~
~~(1) Aged, blind, or disabled;~~
~~(2) The period for which benefits are sought is prior to the date of application;~~
~~(3) Receiving foster care or subsidized adoption benefits; or~~
~~(4) Receiving home and community-based services.~~

~~e. Payment may be made for the following medically necessary covered services whether or not provided by, or upon referral from, a primary care physician:~~
~~(1) Certified family nurse practitioner services;~~
~~(2) Certified pediatric nurse practitioner services;~~
~~(3) Early and periodic screening, diagnosis, and treatment of recipients under twenty-one years of age;~~
~~(4) Family planning services;~~
~~(5) Certified nurse midwife services;~~
~~(6) Pediatric services;~~
~~(7) Optometric services;~~
~~(8) Chiropractic services;~~
~~(9) Clinic services;~~
~~(10) Dental services, including orthodontic services only upon referral from early and periodic screening, diagnosis, and treatment;~~
~~(11) Intermediate care facility services for the mentally retarded;~~
~~(12) Emergency services;~~
~~(13) Transportation services;~~
~~(14) Case management services;~~
~~(15) Home and community-based services;~~
~~(16) Nursing facility services;~~
~~(17) Prescribed drugs except as provided in section 75-02-02-27;~~
~~(18) Psychiatric services;~~
~~(19) Ophthalmic services;~~
~~(20) Obstetrical services;~~
~~(21) Psychological services;~~
~~(22) Ambulance services;~~
~~(23) Immunizations;~~
~~(24) Independent laboratory and radiology services; and~~
~~(25) Public health unit services.~~
~~(26) Personal care services.~~

~~f. Except as provided in subdivision d, and if the department exempts the recipient, a primary care physician must be selected for each recipient.~~

~~g. Primary care physicians may be changed at any time within ninety days after the recipient is informed of the requirements of this subsection, at redetermination of eligibility, and once every six months with good cause. Good cause for changing primary care physicians less than six months after a previous selection of a primary care physician exists if:~~

~~(1) The recipient relocates;~~

~~(2) Significant changes in the recipient's health require the selection of a primary care physician with a different specialty;~~

~~(3) The primary care physician relocates or is reassigned;~~

~~(4) The selected physician refuses to act as a primary care physician or refuses to continue to act as a primary care physician; or~~

~~(5) The department, or its agents, determine, in the exercise of sound discretion, that a change of primary care physician is necessary.~~

~~7. Covered medical or remedial services or supplies are medically necessary when determined so by the medical provider unless the department has:~~

~~a. Required a prior treatment authorization request that was not granted;~~

~~b. Imposed a limit that is exceeded;~~

~~c. Imposed a condition that was not met;~~

~~d. Specifically reserved authority to make determinations of medical necessity; or~~

~~e. Upon review, determined that the service or supplies are not medically necessary.~~

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.
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. Section 75-02-02-09 is amended as follows:

75-02-02-09. Nursing facility level of care.

1. "Nursing facility level of care" means, for purposes of medical assistance, services provided by a facility that meets the standards for nursing facility licensing established by the state department of health, and in addition,

meets all requirements for nursing facilities imposed under federal law and regulations governing the medical assistance program.

2. Except as provided in subsection 3 or 4, an individual who applies for care in a nursing facility, or who resides in a nursing facility, may demonstrate that a nursing facility level of care is medically necessary only if any one of the criteria in this subsection is met.
   a. The individual's nursing facility stay is, or is anticipated to be, temporary for receipt of medicare part A benefits. A nursing facility stay may be based on this criterion for no more than fourteen days after termination of medicare part A benefits.
   b. The individual is in a comatose state.
   c. The individual requires the use of a ventilator at least six hours per day, seven days a week.
   d. The individual has respiratory problems that require regular treatment, observation, or monitoring that may only be provided by or under the direction of a registered nurse or, in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse, and is incapable of self-care.
   e. The individual requires constant help sixty percent or more of the time with at least two of the activities of daily living of toileting, eating, transferring, and locomotion. For purposes of this subdivision, constant help is required if the individual requires a caregiver's continual presence or help without which the activity would not be completed.
   f. The individual requires aspiration for maintenance of a clear airway.
   g. The individual has dementia, physician-diagnosed or supported with corroborative evidence, for at least six months, and as a direct result of that dementia, the individual's condition has deteriorated to the point when a structured, professionally staffed environment is needed to monitor, evaluate, and accommodate the individual's changing needs.
3. If no criteria of subsection 2 is met, an individual who applies for care in a nursing facility or who resides in a nursing facility may demonstrate that a nursing facility level of care is medically necessary if any two of the criteria in this subsection are met.
   a. The individual requires administration of prescribed:
      (1) Injectable medication;
      (2) Intravenous medication or solutions on a daily basis; or
      (3) Routine oral medications, eye drops, or ointments on a daily basis.
   b. The individual has one or more unstable medical conditions requiring specific and individual services on a regular and continuing basis that can only be provided by or under the direction of a registered nurse or, in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse.

c. The individual is determined to have restorative potential and can benefit from restorative nursing or therapy treatments, such as gait training or bowel and bladder training, which are provided at least five days per week.

d. The individual requires administration of feedings by nasogastric tube, gastrostomy, jejunostomy, or parenteral route.

e. The individual requires care of decubitus ulcers, stasis ulcers, or other widespread skin disorders.

f. The individual requires constant help sixty percent or more of the time with any one of the activities of daily living of toileting, eating, transferring, or locomotion. For purposes of this subdivision, constant help is required if the individual requires a caregiver's continual presence or help without which the activity would not be completed.

4. If no criteria of subsection 2 or 3 is met, an individual who applies to or resides in a nursing facility designated as a facility for nongeriatric individuals with physical disabilities may demonstrate that a nursing facility level of care is medically necessary if the individual is determined to have restorative potential.

5. If no criteria of subsection 2, 3, or 4 is met, an individual who applies for care in a nursing facility may demonstrate that a nursing level of care is medically necessary if:

   a. The individual has an acquired brain injury, including anoxia, cerebral vascular accident, brain tumor, infection, or traumatic brain injury; and

   b. As a result of the brain injury, the individual requires direct supervision at least eight hours a day, seven days a week.

6. a. Payment, by the department of human services, for care furnished in a nursing facility to individuals who were applicants for or recipients of medical assistance benefits prior to admission to the nursing facility may be made only for periods after a nursing facility level of care determination is made. If a nursing facility admits an individual who has applied for or is receiving medical assistance benefits before a nursing facility level of care determination is made, the nursing facility may not solicit or receive payment, from any source, for services furnished before the level of care determination is made.

   b. Payment, by the department of human services, for care furnished in a nursing facility to individuals who become applicants for or recipients of medical assistance benefits after admission to the nursing facility may be made only after a nursing facility level of care determination is made.

   c. Payment, by the department of human services, for care furnished in a nursing facility to individuals who are eligible for medicare benefits related to that care, and who are also eligible for medical

assistance, may be made only after a nursing facility level of care determination is made.

7. A nursing facility shall ensure that appropriate medical, social, and psychological services are provided to each resident of the facility who is dependent in whole or in part on the medical assistance program under title XIX of the Social Security Act. The appropriateness of such services must be based on the need of each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and must consider, among other factors, age.

History: Amended effective September 1, 1979; July 1, 1993; November 1, 2001; July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 442

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 in a nursing facility, intermediate care facility for the mentally retarded, or the state hospital;
      (2) Receives swing-bed services in a hospital;
      (3) Has not reached the age of twenty-one years; ~~or~~
      (4) Is pregnant;
      (5) Is an Indian who receives services from Indian health services providers or through referral by contract health services; or
      (6) Is terminally ill and is receiving hospice care.
   b. The service is:
      (1) Emergency room services that are elective or not urgent; or
      (2) Family planning services.
2. Copayments are:
   a. Seventy-five dollars for each inpatient hospital admission ~~except~~ including admissions to distinct part psychiatric and rehabilitation units of hospitals ~~paid as psychiatric, rehabilitative, or~~ and excluding long-term hospitals;
   b. ~~Six~~ Three dollars for each nonemergency ~~service provided in a~~ visit to a hospital emergency room;
   c. Two dollars for each ~~physician~~ doctor of medicine or osteopathy visit;
   d. Three dollars for each office visit to a rural health clinic or federally qualified health center;
   e. One dollar for each chiropractic ~~visit~~ manipulation of the spine;
   f. Two dollars for each ~~preventive~~ dental ~~office~~ 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 ~~fee~~ service;
n. Two dollars for each audiology testing visit; ~~and~~
o. Two dollars for each psychological 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.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

SECTION 5. Section 75-02-02-09.3 is amended as follows:

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

1. No payment will be made for single crowns on posterior teeth for individuals twenty-one years of age and older except for stainless steel crowns. Payment for other crowns may be allowed by the department for the anterior portion of the mouth for adults if the crown is necessary and has been previously approved by the department.
2. No payment will be made for single crowns on posterior teeth for individuals less than twenty-one years of age except for stainless steel crowns. Payment may be made if a dental condition exists that makes stainless steel crowns impracticable and the provider has secured the prior approval of the department.
3. ~~No payment~~ Payment will be made for partial dentures ~~except~~ 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 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 July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

SECTION 6. Section 75-02-02-09.4 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.

~~1.~~2. Limitations on payment for occupational therapy, physical therapy, and speech therapy.
   a. No payment will be made 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 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 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 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 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 services delivered by independent speech therapists and in outpatient hospital settings. This limit does not apply to school-based services for children.

~~2.~~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.

~~3.~~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.

~~4.~~5. No payment will be made for psychological visits except for forty visits per individual 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.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

SECTION 7. Section 75-02-02-09.5 is amended as follows:

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

1. No payment for personal care services may be made unless an assessment of the recipient is made by the department or the department's designee and the recipient is determined to be impaired in at least one of the activities of daily living of bathing, dressing, eating, incontinence, mobility, toileting, and transferring or in at least three of the instrumental activities of daily living of medication assistance, laundry, housekeeping, and meal preparation.
2. No payment may be made for personal care services unless prior authorization has been granted by the department.
3. Payment for personal care services may only be made to an enrolled qualified service provider who meets the standards described in chapter 75-03-23 or to a basic care assistance provider that qualifies for a rate under chapter 75-02-07.1.
4. No payment may be made for personal care services provided in excess of the services, hours, or timeframe authorized by the department in the recipient's approved service plan.
5. Personal care services may not include skilled health care services performed by persons with professional training.
6. An inpatient or resident of a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental ~~disease~~ diseases may not receive personal care services.
7. Personal care services may not include home-delivered meals, services performed primarily as housekeeping tasks, transportation, social activities, or services or tasks not directly related to the needs of the recipient such as doing laundry for family members, cleaning of areas not occupied by the recipient, ~~or~~ shopping for items not used by the recipient,

or for tasks when they are completed for the benefit of both the client and the provider.

8. Payment for the tasks of laundry, shopping, housekeeping, meal preparation, money management, and communication cannot be made to a provider who lives with the client and is a relative listed under the definition of family home care under subsection 4 of North Dakota Century Code section 50-06.2-02 or is a former spouse.

9. Meal preparation is limited to the maximum units set by the department. Laundry, shopping, and housekeeping tasks when provided as personal care services must be incidental to the provision of other personal care tasks and cannot exceed thirty percent of the total time authorized for the provision of all personal care tasks. Personal care service tasks of laundry, shopping, and housekeeping are limited to the maximum units set by the department, and the cap cannot be exceeded under other home and community based services funding sources.

~~9.~~10. No payment may be made for personal care services provided to a recipient by the recipient's spouse, parent of a minor child, or legal guardian.

~~10.~~11. No payment may be made for care needs of a recipient which are outside the scope of personal care services.

~~11.~~12. Authorized personal care services may only be approved for:

a. Up to one hundred twenty hours per month, or at a daily rate;

b. Up to two hundred forty hours per month, or at a daily rate, if the recipient meets the medical necessity criteria for nursing facility level of care described in section 75-02-02-09 or intermediate care facility for the mentally retarded level of care; or

c. Up to three hundred hours per month if the recipient is determined to be impaired in at least five of the activities of daily living of bathing, dressing, eating, incontinence, mobility, toileting, and transferring; meets the medical necessity criteria for nursing facility level of care described in section 75-02-02-09 or intermediate care facility for the mentally retarded level of care; and none of the three hundred hours approved for personal care services are allocated to the tasks of laundry, shopping, or housekeeping.

~~12.~~13. Personal care services may only be provided when the needs of the recipient exceed the abilities of the recipient's spouse or parent of a minor child to provide those services. Personal care services may not be substituted when a spouse or parent of a minor child refuses or chooses not to perform the service for a recipient. Personal care services may be provided during periods when a spouse or parent of a minor child is gainfully employed if the services cannot be delayed until the spouse or parent is able to perform them.

~~13.~~14. Personal care services may not be provided for tasks that are otherwise age appropriate or generally needed by an individual within the normal stages of development.

~~14.~~15. The authorization for personal care services may be terminated if the services are not used within sixty days, or if services lapse for at least sixty days, after the issuance of the authorization to provide personal care services.

~~15.~~16. The department may deny or terminate personal care services when service to the client presents an immediate threat to the health or safety of the client, the provider of services, or others, or when services that are available are not adequate to prevent a threat to the health or safety of the client, the provider of services, or others.

17. Decisions regarding personal care services for an incapacitated client are health care decisions that may be made pursuant to North Dakota Century Code section 23-12-13.

18. The applicant or guardian of the applicant shall provide information sufficient to establish eligibility for benefits, including a social security number, proof of age, identity, residence, blindness, disability, functional limitation, financial eligibility, and such other information as may be required by this chapter for each month for which benefits are sought.

19. Payment for personal care services may not be made unless the client has been determined eligible to receive medicaid benefits.

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

SECTION 8. Section 75-02-02-03.2 is amended as follows:

75-02-02-10. Limitations on inpatient psychiatric services.

1. Inpatient psychiatric services for individuals under age twenty-one must be provided:
   a. Under the direction of a physician;
   b. By a psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the joint commission on accreditation of health care organizations, or by a psychiatric facility that is not a hospital and which is accredited by the joint commission on accreditation of health care organizations, the commission on accreditation of rehabilitation facilities, the council on accreditation of services for families and children, or by any other accrediting organization with comparable standards; and
   c. Before the individual reaches age twenty-one, or, if the individual was receiving inpatient psychiatric services immediately before reaching age twenty-one, before the earlier of:
      (1) The date the individual no longer requires inpatient psychiatric services; or
      (2) The date the individual reaches age twenty-two.
2. A psychiatric facility or program providing inpatient psychiatric services to individuals under age twenty-one ~~must~~ shall:

a. Except as provided in subdivision c, obtain a certification of need from an independent review team qualified under subsection 3 prior to admitting an individual who is eligible for medical assistance;

b. Obtain a certification of need from ~~a team responsible for developing a plan of care under 42 CFR 441.156~~ an independent review team qualified under subsection 3 for an individual who applies for medical assistance while in the facility or program covering any period for which claims are made; or

c. Obtain a certification of need from ~~a team responsible for developing a plan of care under 42 CFR 441.156~~ an independent review team qualified under subsection 3 for an emergency admission of an individual, within fourteen days after the admission, covering any period prior to the certification for which claims are made.

3. a. An independent review team must:
   (1) Be composed of individuals who have no business or personal relationship with the inpatient psychiatric facility or program requesting a certification of need;
   (2) Include a physician;
   (3) Have competence in diagnosis and treatment of mental illness; and
   (4) Have adequate knowledge of the situation of the individual for whom the certification of need is requested.

   b. Before issuing a certification of need, an independent review team must use professional judgment and standards approved by the department and consistent with the requirements of 42 CFR part 441, subpart D, to demonstrate:
   (1) Ambulatory care resources available in the community do not meet the treatment needs of the individual;
   (2) Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
   (3) The requested services can reasonably be expected to improve the individual's condition or prevent further regression so services may no longer be needed.

4. No payment will be made for inpatient psychiatric services provided to an individual, other than those described in subsection 1, in a distinct part unit of a hospital except for the first twenty-one days of each admission. Payment may not be made for inpatient psychiatric services exceeding forty-five days per calendar year per individual.

History: Amended effective January 1, 1997; November 1, 2001; November 8, 2002; July 1, 2006; July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 441, subpart D

SECTION 9. Section 75-02-02-10.1 is amended as follows:

75-02-02-10.1. Limitations on ~~rehabilitative~~ services in psychiatric residential treatment ~~centers~~ facilities.

1. A psychiatric residential treatment ~~center~~ facility providing rehabilitative services to individuals under the age of twenty-one must obtain a certification of need from an independent review team:
   a. Prior to admitting an individual who is eligible for medical assistance;
   b. For an individual who applies for medical assistance while in the facility; or
   c. For an individual who applies for medical assistance after receiving services.
2. Before issuing a certification of need, an independent review team must demonstrate that:
   a. Ambulatory care resources available in the community do not meet the treatment needs of the individual;
   b. Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
   c. The requested services can reasonably be expected to improve the individual's condition or prevent further regression so services may no longer be needed.
3. An independent review team must:
   a. Be composed of individuals who have no business or personal relationship with the psychiatric residential treatment ~~center~~ facility requesting a certification of need;
   b. Include a physician;
   c. Have competence in diagnosis and treatment of mental illness; and
   d. Have adequate knowledge of the situation of the individual for whom the certification is requested.
4. Payment ~~will~~ may not be made for ~~rehabilitation~~ services provided to a recipient under the age of twenty-one in a psychiatric residential treatment ~~center~~ facility without a certification of need.
5. Payment may not be made for any other medical services not provided by a psychiatric residential treatment facility if the facility is an institution for mental diseases.

History: Effective November 1, 2001; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04; 42 CFR 456.1; 42 CFR 456.3
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 441, subpart D

SECTION 10. Section 75-02-02-10.2 is amended as follows:

75-02-02-10.2. Limitations on ambulatory behavioral health care.

1. For purposes of this section:
   a. "Ambulatory behavioral health care" means ambulatory services provided to an individual with a significant impairment resulting from

a psychiatric, emotional, behavioral, or addictive disorder which are provided by a multidisciplinary team of health care professionals and are designed to stabilize the health of the individual with the intent to avert inpatient hospitalization in place of inpatient hospitalization or to reduce the length of a hospital stay.

b. "Level A ambulatory behavioral health care" means an intense level of ambulatory behavioral health care which provides treatment for an individual by at least three licensed health care professionals under the supervision of a licensed physician for at least four hours and no more than eleven hours per day for at least three days per week.

c. "Level B ambulatory behavioral health care" means an intermediate level of ambulatory behavioral health care that provides treatment for an individual by at least three licensed health care professionals under the supervision of a licensed physician for three hours per day for at least two days per week.

d. "Level C ambulatory behavioral health care" means a low level of ambulatory behavioral health care that provides chemical dependency treatment for an individual by at least one licensed health care professional under the supervision of a licensed physician for less than three hours per day and no more than three days per week.

2. No payment for ambulatory behavioral health care will be made unless the provider requests authorization from the department within three business days of providing such services and the department approves such request. A provider must submit a written request for authorization to the department on forms prescribed by the department.

3. Limitations.

a. Payment may not be made for level A ambulatory behavioral health care services exceeding thirty days per calendar year per individual.

b. Payment may not be made for level B ambulatory behavioral health care services exceeding fifteen days per calendar year per individual.

c. Payment may not be made for level C ambulatory behavioral health care services exceeding twenty days per calendar year per individual.

History: Effective November 8, 2002; amended effective November 19, 2003; July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 441-431.54

SECTION 11. Section 75-02-02-11 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 ~~in order~~ to prevent the continued misutilization of services.

b. "Coordinated services provider" means a physician, nurse practitioner, or Indian health services 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.

2. Coordinated services may be required by the department of a recipient who has misutilized services, including:

a. Securing excessive services from more than one provider when there is little or no evidence of a medical need for those services;

b. Drug acquisition in excess of medical need resulting from securing prescriptions or drugs from more than one provider; or

c. Excessive utilization of emergency services when no medical emergency is present.

3. The determination to require coordinated services of a recipient is made by the department upon recommendation of medical professionals who have reviewed and identified the services the recipient appears to be misutilizing.

4. The following factors must be considered in determining if coordinated services is to be required:

a. The seriousness of the misutilization;

b. The historical utilization of the recipient; and

c. The availability of a coordinated services physician or provider.

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. A coordinated services recipient may have a coordinated services provider in more than one medical specialty.

~~5.~~6. Upon a determination to require coordinated services:

a. The department shall provide the recipient with written notice of:

(1) The decision to require coordinated services;

(2) The recipient's right to choose a coordinated services provider, subject to approval by the department and acceptance by the provider;

(3) The recipient's responsibility to pay for medical care or services rendered by any provider other than the coordinated services provider; and

(4) The recipient's right to appeal the requirement of enrollment into the coordinated services program.

b. The appropriate county agency shall:

(1) Obtain the recipient's selection of a coordinated services provider; and

(2) Document that selection in the case record.

~~6.~~7. Coordinated services may be required of an individual recipient and may not be imposed on an entire medical assistance ~~unit~~ case. If more than one recipient within a ~~unit~~ case is misutilizing medical care, each individual recipient must be treated separately.

~~7.~~8. Coordinated services may be required without regard to breaks in eligibility until the department determines coordinated services is discontinued.

~~8.~~9. No medical assistance payment may be made for misutilized medical care or services furnished to the coordinated services recipient by any provider other than the recipient's coordinated services physician or provider, except for:

a. Medical care rendered in a medical emergency; or

b. Medical care rendered by a provider upon referral by the coordinated services physician or provider and approved by the department.

~~9.~~10. A recipient may appeal the decision to require coordinated services in the manner provided by chapter 75-01-03.

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

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

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

1. For purposes of this section, "screening" means the initial evaluation of an individual, intended to determine suitability for a particular medical treatment modality.

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, if a medical emergency exists;

d. ~~If it is determined that the patient is a recipient, making an~~ An attempt is made to contact the recipient's personal ~~physician, or one substituting for that physician,~~ primary care provider to approve services before they are given~~, unless a medical emergency exists~~;

e. Referral to the recipient's ~~physician'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.

~~2.~~3. Physician providers shall:

a. Determine when a medical emergency exists; and

b. Assure that a recipient is referred to the appropriate health delivery setting when emergency room services are not judged to be appropriate.

~~3.~~4. Payment for emergency room services.

a. Claims for payment, and documentation in support of those claims, must be submitted on forms prescribed by the department. The claim must contain sufficient documentation to indicate that a medical emergency required emergency room diagnostic services and treatment.

b. Except as provided in subsection 45, providers must be paid for any medically necessary services authorized by a physician or nurse practitioner, which fact is properly noted on the request for payment.

c. Except as provided in subsection 45, providers must be paid for screening or examination services rendered.

d. Providers must be paid for services rendered to patients who reside outside of the provider's regular service area and who do not normally utilize the provider's services.

~~4.~~5. If the emergency room service claim does not demonstrate the existence of a medical emergency, payment must be denied (except for screening services) unless the services are shown to be medically necessary by ~~special report~~ a redetermination. The provider, upon receipt of notice of denial, may, in writing, make a ~~special report~~ redetermination request to the department. A ~~special report~~ redetermination must include a statement refuting the stated basis for the payment denial and affirmatively demonstrating a medical emergency.

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

SECTION 13. Section 75-02-02-13 is amended as follows:

75-02-02-13. Limitations on out-of-state care.

1. For purposes of this section:

a. "Out-of-state care" means care or services furnished by any individual, entity, or facility, pursuant to a provider agreement with the department, at a site located more than fifty statute miles [80.45 kilometers] from the nearest North Dakota border.

b. "Out-of-state provider" means a provider of care or services that is located more than fifty statute miles outside of North Dakota. An out-of-state provider may be an individual or a facility but may not be located outside of the United States.

c. "Primary ~~physician~~ care provider" means the ~~individual physician~~ enrolled medical provider who has assumed responsibility for the advice and care of the recipient.

~~c.~~d. "Specialist" means a physician board certified in the required medical specialty who regularly practices within North Dakota or at a site within fifty statute miles [80.45 kilometers] from the nearest North Dakota border.

2. Except as provided in subsection 3, no payment for out-of-state care, including related travel expenses, will be made unless:

   a. The medical assistance recipient was first seen by that recipient's primary ~~physician~~ care provider;

   b. The primary ~~physician~~ care provider determines that it is advisable to refer the recipient for care or services which the primary ~~physician~~ care provider is unable to render;

   c. A request for active treatment is first made to ~~a~~ an in-state, board certified physician specialist, if available;

   d. The specialist concludes that the patient should be referred to an appropriate out-of-state provider because necessary care or services are unavailable in the state;

   e. The primary care provider or physician ~~or~~ specialist submits, to the department, a written request that includes medical and other pertinent information, including the report of the specialist that documents the specialist's conclusion that the out-of-state referral is medically necessary;

   f. The department determines that the medically necessary care and services are unavailable in the state and approves the referral on that basis; and

   g. The claim for payment is otherwise allowable and verifies that the department approved the referral for out-of-state care.

3. a. A referral for emergency care, including related travel expenses, to an out-of-state provider can be made by the in-state primary ~~physician~~ care provider. A determination that the emergency requires out-of-state care may be made at the primary ~~physician's~~ care provider's discretion, but is subject to review by the department. Claims for payment for such emergency services must identify the referring ~~physician~~ primary care provider and document the emergency.

   b. Claims for payment for care for a medical emergency or surgical emergency, as those terms are defined in section 75-02-02-12, which occurs when the affected medical assistance recipient is traveling outside of North Dakota, will be paid unless payment is denied pursuant to limitations contained in section 75-02-02-12.

   c. Claims for payment for any covered service rendered to an eligible medical assistance recipient who is a resident of North Dakota for medical assistance purposes, but whose current place of abode is outside of North Dakota, will not be governed by this section.

d. Claims for payment for any covered service rendered to an eligible medical assistance recipient during a verified retroactive eligibility period will not be governed by this section.

e. If a recipient is referred for out-of-state care without first securing approval under subsection 2, and the care is not otherwise allowable under this subsection, the department may approve payment upon receipt of a written request, from the primary ~~physician~~ care provider or specialist, that:

(1) Demonstrates good cause for not first securing approval under subsection 2;

(2) Clearly establishes that the care and services were unavailable in the state; and

(3) Documents that the care and services were medically necessary.

4. An out-of-state provider who does not maintain a physical, in-state location or a location within fifty statute miles of North Dakota, will not be enrolled as a medicaid provider unless the department determines the provider's enrollment is necessary to ensure access to covered services.

History: Effective November 1, 1983; amended effective October 1, 1995; July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-02

SECTION 14. Section 75-02-02-13.1 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, taxi, bus, ~~or~~ a food service provider, a lodging provider, an airline service provider, a travel agency, or ~~other~~ 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. ~~The~~ Upon approval, the county agency may ~~authorize~~ 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 is court appointed for foster care, kinship, or guardianship, may enroll as a transportation provider and are eligible for reimbursement to transport a child in the individual's court-appointed custody to and from 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 ~~transport~~ transportation by ambulance is a covered service only when medically necessary and ordered by the attending ~~physician~~ 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~~, without a referral from a primary physician~~ 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 visits, may be ~~compensated only~~ 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 non-commercial vehicle mileage compensation is limited to an amount set by the department ~~no less than twenty cents per mile~~ 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 ~~authorize~~ request authorization from the department to make payment for additional mileage. Private vehicle mileage may be billed to medical assistance only upon completion of the service. ~~Private vehicle mileage~~ 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. ~~Private vehicle mileage will not be allowed if~~ 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.

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 ~~no less than three dollars and fifty cents for breakfast, five dollars for lunch, and eight dollars and fifty cents for dinner~~ based on the department's fee schedule.

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, ~~provided the department may set no limit lower than thirty-five dollars per night, plus taxes, for in-state travel and fifty dollars per night, plus taxes, for out-of-state travel. Lodging receipts must be provided when lodging is not billed directly by an enrolled lodging provider. Enrolled lodging~~ based on the appropriate fee schedule. Lodging providers ~~shall bill~~ must be enrolled in medicaid ~~directly~~ and shall submit the proper forms for payment.

d. ~~Travel expenses may be authorized for a driver. No travel expenses may be authorized for an attendant unless the referring physician determines an attendant is necessary for the physical or medical needs of the recipient.~~ Travel expenses may not be authorized for both a driver and an attendant unless the referring ~~physician~~ licensed practitioner determines that one individual cannot function both as driver and attendant. ~~No travel~~ Travel expenses may not be allowed for a non-commercial 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 ~~physician~~ licensed practitioner determines that person's presence is necessary for the physical 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.

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

SECTION 15. Section 75-02-02-13.2 is amended as follows:

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

1. For purposes of this section:
   a. "Long-term care facility" means a nursing facility, intermediate care facility for the mentally retarded, or swing-bed facility; and
   b. "Medical center city" means Bismarck, Devils Lake, Dickinson, Fargo, Grand Forks, Jamestown, Minot, and Williston, and includes any city that shares a common boundary with any of those cities.
2. A long-term care facility may not charge a resident for the cost of travel ~~expenses for services~~ provided by the facility. Except as provided in subsection 3, a long-term care facility shall provide transportation to and from any provider of necessary medical services located within, or at no greater distance than the distance to, the nearest medical center city. Distance must be calculated by road miles.
3. If the resident has to travel farther than the nearest 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.
4. A long-term care facility ~~need not provide either nonemergency transport~~ is not required to pay for transportation by ambulance ~~when medically necessary and ordered by the attending physician or~~ for emergency ~~transport by ambulance~~ or non-emergent situations for residents.
4.5. A service provider that is paid a rate, determined by the department on a cost basis that includes transportation service expenses, however denominated, may not be compensated as a transportation service provider for transportation services provided to an individual residing in the provider's facility. The following service providers may not be so compensated:
   a. ~~Accredited residential treatment centers;~~
   ~~b.~~ Basic care facilities;
   ~~c.~~b. Congregate care facilities serving individuals with developmental disabilities;
   ~~d.~~c. Group homes serving children in foster care;
   ~~e.~~d. Intermediate care facilities for the mentally retarded;
   ~~f.~~e. Minimally supervised living arrangement facilities serving individuals with developmental disabilities;
   ~~g.~~f. Nursing facilities;
   ~~h.~~g. Psychiatric residential treatment facilities;
   h. Residential child care facilities;
   i. ~~Residential treatment centers for children;~~
   ~~j.~~ Swing-bed facilities; and
   ~~k.~~j. Transitional community living facilities serving individuals with developmental disabilities.
5.6. If, under the circumstances, a long-term care facility is not required to transport a resident, and the facility does not actually transport the resident, the availability of transportation services and payment of travel expenses is governed by section 75-02-02-13.1.

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

SECTION 16. Section 75-02-02-14 is amended as follows:

75-02-02-14. County administration.

1. Except as provided in subsection 2, the county where the medical assistance unit is physically present is responsible for the administration of the program with respect to that unit.
2. When a ~~family~~ unit receiving assistance moves from one county to another, the outgoing county continues to be responsible for the administration of the program with respect to that unit until the last day of the month after the month in which the unit assumes physical residence in an incoming county.

History: Effective November 1, 1983; amended effective July 1, 1984; May 1, 1986; May 1, 2000; July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-01.2-03

SECTION 17. Section 75-02-02-27 is amended as follows:

75-02-02-27. Scope of drug benefits - Prior authorization.

1. Prior authorization means a process requiring the prescriber or the dispenser to verify with the department or the department's contractor that proposed medical use of a particular drug for a medical assistance program recipient meets predetermined criteria for coverage by the medical assistance program.
2. A prescriber or a dispenser must secure prior authorization from the department or its designee as a condition of payment for those drugs subject to prior authorization.
3. A prescriber or a dispenser must provide to the department or its designee in the format required by the department the data necessary for the department or its designee to make a decision regarding prior authorization. The department shall deny a claim for coverage of a drug requiring prior authorization if the prescription was dispensed prior to authorization or if the required information regarding the prior authorization is not provided by the prescriber or the dispenser.
4. A prescriber or dispenser must submit a request for prior authorization to the department or its designee by telephone, facsimile, electronic mail, or in any other format designated by the department. The department or its designee must respond to a prior authorization request within twenty-four hours of receipt of a complete request that contains all of the data necessary for the department to make a determination.
5. Emergency supply.

a. If a recipient needs a drug before a prescriber or dispenser can secure prior authorization from the department, the department shall provide coverage of the lesser of a five-day supply of a drug or the amount prescribed if it is not feasible to dispense a five-day supply because the drug is packaged in such a way that it is not intended to be further divided.
b. The department will not provide further coverage of the drug beyond the five-day supply unless the prescriber or dispenser first secures prior authorization from the department.

6. The department must authorize the provision of a drug subject to prior authorization if:
   a. Other drugs not requiring prior authorization have not been effective or with reasonable certainty are not expected to be effective in treating the recipient's condition;
   b. Other drugs not requiring prior authorization cause or are reasonably expected to cause adverse or harmful reactions to the health of the recipient; or
   c. The drug is prescribed for a medically accepted use supported by a compendium or by approved product labeling unless there is a therapeutically equivalent drug that is available without prior authorization.
7. If a recipient is receiving coverage of a drug that is later subject to prior authorization requirements, the department shall continue to provide coverage of that drug until the prescriber must reevaluate the recipient. The department ~~shall develop~~ will provide a form by which a prescriber may inform the department of a drug that a recipient must continue to receive beyond the prescription reevaluation period regardless of whether such drug requires prior authorization. The form shall contain the following information:
   a. The requested drug and its indication;
   b. An explanation as to why the drug is medically necessary; and
   c. The signature of the prescriber confirming that the prescriber has considered generic or other alternatives and has determined that continuing current therapy is in the best interest for successful medical management of the recipient.
8. Except for quantity limits that may be no less than the pharmaceutical manufacturer's package insert or AB-rated generic equivalent drug for which the cost to the state postrebate is less than the brand name drugs, in the aggregate, the department may not ~~require~~ prior ~~authorization for, or otherwise restrict, single-source or brand name antipsychotic, antidepressant, or other medications used to treat mental illnesses such as schizophrenia, depression, or bipolar disorder, and drugs prescribed for the treatment of~~ authorize the following medication classes:
   a. ~~Acquired immune deficiency syndrome or human immunodeficiency virus; or~~ Antipsychotics;
   b. ~~Cancer~~ Antidepressants;

c. Anticonvulsants;
d. Antiretrovirals for the treatment of human immunodeficiency virus;
e. Antineoplastic agents for the treatment of cancer; and
f. Stimulant medication used for the treatment of attention deficit disorder and attention deficit hyperactivity disorder.

History: Effective September 1, 2003; amended effective July 26, 2004; July 1, 2006; July 1, 2012.
General Authority: NDCC 50-24.6-10
Law Implemented: NDCC 50-24.6; 42 USC 1396r-8

SECTION 18. Section 75-02-02-28 is amended as follows:

75-02-02-28. Drug use review board~~, grievances,~~ and appeals.

1. The department shall implement a prospective and retrospective drug use review program for outpatient prescription drugs and determine which drugs shall be subject to prior authorization before payment will be approved. The department shall consider the advice and recommendations of the drug use review board before requiring prior authorization of any drug.
2. The drug use review board shall:
   a. Cooperate with the department to implement a drug use review program;
   b. Receive and consider information regarding the drug use review process which is provided by the department and interested parties, including prescribers who treat significant numbers of recipients;
   c. Review and make recommendations to the department regarding drugs to be included on prior authorization status;
   d. Review no less than once each year the status of the drugs that have been deemed to require prior authorization and make recommendations to the department regarding any suggested changes;
   e. Review and approve the prior authorization program process used by the department, including the process to accommodate the provision of a drug benefit in an emergency situation;
   f. Advise and make recommendations to the department regarding any rule proposed for adoption by the department to implement the provisions of state and federal law related to drug use review; and
   g. Propose remedial strategies to improve the quality of care and to promote effective use of medical assistance program funds or recipient expenditures.
3. The drug use review board may establish a panel of physicians and pharmacists to provide guidance and recommendations to the board in considering specific drugs or therapeutic classes of drugs to be included in the prior authorization program.
4. The drug use review board shall make a recommendation to the department regarding prior authorization of a drug based on:

a. Consideration of medically and clinically significant adverse side effects, drug interactions and contraindications, assessment of the likelihood of significant abuse of the drug, and any other medically and clinically acceptable analysis or criteria requested by the drug use review board; and

b. An assessment of the cost-effectiveness of the drug compared to other drugs used for the same therapeutic indication and whether the drug offers a clinically meaningful advantage in terms of safety, effectiveness, or clinical outcome over other available drugs used for the same therapeutic indication.

5. Drug use review board meeting procedures.

a. Any interested party may address the drug use review board at its regular meetings if the presentation is directly related to an agenda item.

b. The drug use review board may establish time limits for presentations.

c. The department shall post on its web site the proposed date, time, location, and agenda of any meeting of the drug use review board at least thirty days before the meeting.

6. Within thirty days of the date the drug use review board's recommendation is received by the department, the department shall review the recommendations and make the final determination as to whether a drug requires prior authorization and, if so, when the requirement for prior authorization will begin. If the department's final determination is different from the recommendation of the drug use review board, the department shall present, in writing, to the drug use review board at its next meeting the basis for the final determination.

7. The department shall post on its web site the list of drugs subject to prior authorization and the date on which each drug became subject to prior authorization.

8. ~~Grievances.~~

~~a. An interested party may file a grievance with the department regarding a decision of the department to place a drug on prior authorization. In order to be considered by the department, the grievance must:~~

~~(1) Be in writing;~~

~~(2) State the specific reasons the interested party believes the decision to be erroneous or not, based on the facts available to the department at the time of the decision;~~

~~(3) Provide any supporting documentation; and~~

~~(4) Be received by the department within forty-five days of the department's final determination to include the drug on prior authorization.~~

~~b. The department shall consider all grievances that were filed in a timely manner. Within thirty days after the time for filing grievances has expired, the department shall determine whether to change its~~

~~decision regarding placing a drug on prior authorization. The requirement for prior authorization shall not be suspended during the department's review of timely filed grievances.~~

~~9.~~ A recipient may appeal the department's denial, suspension, reduction, or termination of a covered drug based upon application of this section as authorized under North Dakota Century Code chapter 28-32.

History: Effective September 1, 2003; amended effective July 1, 2012.
General Authority: NDCC 50-24.6-10
Law Implemented: NDCC 50-24.6; 42 USC 1396r-8

SECTION 19. Section 75-02-02-30 is created as follows:

75-02-02-30. 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 medical assistance unit which includes:
   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; or
(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.

3. A physician or nurse practitioner 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. A rural health clinic;
h. A federally qualified health center; or
i. An Indian health services clinic.

4. A recipient identified in subdivision 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.

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 twenty-one years of age;
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 months during the open enrollment period, or with good cause. Good cause for changing a primary care provider less than six 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, determine that a change of a primary care provider is necessary.

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

north dakota
department of
human services

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Jack Dalrymple, Governor
Carol K. Olson, Executive Director

March 16, 2012

RE: Proposed Amendments to N.D. Admin. Code Chapter 75-02-02
Medical Services

TO WHOM IT MAY CONCERN:

The Department of Human Services is proposing amendments to N.D. Admin. Code chapter 75-02-02, Medical Services. 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 Thursday, May 3, 2012.

The department has scheduled an oral hearing on Monday, April 23, 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