SUBCHAPTER 22B – PROVIDER ISSUES

SECTION .0100 - GENERAL

10A NCAC 22B .0101 INSTITUTIONAL HEALTH SERVICES

No provider shall be enrolled in the Medicaid Program to provide any new institutional health service for which a Certificate of Need is required under G.S. 131E, Article 9 without first obtaining a Certificate of Need and meeting the conditions imposed by it.

History Note: *Authority G.S. 108A-25(b); 108A-54;*
Eff. March 1, 1993;
Recodified from 10 NCAC 26B .0124 Eff. October 1, 1993;
Recodified from 10 NCAC 26B .0125 Eff. April 1, 1994;
Recodified from 10 NCAC 26B .0126 Eff. January 1, 1998;
Readopted Eff. July 1, 2018.

10A NCAC 22B .0102 COORDINATION WITH TITLE XVIII

The entire range of benefits under Part B of Title XVIII of the Social Security Act, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at http://uscode.house.gov/, to Medicare-eligible persons shall be provided through a buy-in agreement with the Secretary of Health and Human Services. This agreement shall cover all persons eligible under the Medicaid State Plan.

History Note: *Authority G.S. 108A-25(b); 108A-54;*
Eff. February 1, 1976;
Readopted Eff. October 31, 1977;
Amended Eff. June 1, 1998;
Readopted Eff. July 1, 2018.

10A NCAC 22B .0103 INSTITUTIONAL STANDARDS

Institutions shall meet standards prescribed for participation in Titles XVIII, XIX, and XXI of the Social Security Act, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at http://uscode.house.gov/. These standards are set forth in North Carolina licensing law and federal regulations, and are kept on file in the Department of Health and Human Services, Division of Health Services Regulation and available on request.

History Note: *Authority G.S. 108A-25(b); 108A-54; 131-E; 42 C.F.R. 440.10; 42 C.F.R. Part 442; 42 C.F.R. 457.990;*
Eff. February 1, 1976;
Readopted Eff. October 31, 1977;
Readopted Eff. July 1, 2018.

10A NCAC 22B .0104 TIME LIMITATION

(a) To receive payment, claims shall be filed either:

(1) within 365 days of the date of service for services other than inpatient hospital, home health, or nursing home services;

(2) within 365 days of the date of discharge for inpatient hospital services and the last date of service in the month for home health and nursing home services, not to exceed the limitations as specified in 42 C.F.R. 447.45, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/; or

(3) within 180 days of the Medicare or other third party payment or final denial, when the date of the third party payment or denial exceeds the filing limits in Subparagraphs (1) or (2) of this Paragraph, if it is shown that:

(A) a claim was filed with a prospective third-party payor within the filing limits in Subparagraph (1) or (2) of this Paragraph;

(B) payment from the third party payor with whom the claim was filed is pending; and

(C) documented efforts were made to achieve either payment or final denial of the third-party claim.

(b) Providers shall file requests for payment adjustments or requests for reconsideration of a denied claim no later than 18 months after the date of payment or denial of a claim.

(c) The time limitation specified in Paragraph (a) of this Rule shall be waived by the Division when there is a correction of an administrative error in determining eligibility by the county or application of court order or hearing decision that grants eligibility with less than 60 days for providers to submit claims for eligible dates of service, provided the claim is received for processing within 180 days after the date the county department of social services approves the eligibility.

(d) In cases where claims or adjustments were not filed within the time limitations specified in Paragraphs (a) and (b) of this Rule, and the provider shows good cause for the failure to do so, the provider may request a reconsideration review by the Director of the Division. "Good cause" is an action outside the control of the provider. The Director of the Division shall be the final authority for reconsideration reviews. If the provider wishes to contest this decision, he may do so by filing a petition for a contested case hearing in conformance with G.S. 150B-23.

History Note: *Authority G.S. 108A-25(b); 108A-54; 42 C.F.R. 447.45;*
Eff. February 1, 1976;
Amended Eff. October 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. June 1, 1993; June 1, 1988; November 1, 1986; July 1, 1985;
Readopted Eff. July 1, 2018.

10A NCAC 22B .0105 OVERUTILIZER IDENTIFICATION

History Note: *Authority G.S. 108A-25(b);*
Eff. January 1, 1978;
Amended Eff. May 1, 1990; October 4, 1979;
Repealed Eff. July 1, 2018.

SECTION .0200 - MANUALS AND FORMS

10A NCAC 22B .0201 MANUALS

Manuals and bulletins explaining Medicaid procedures are available through the private contractor mentioned in 10A NCAC 22A .0101.

History Note: *Authority G.S. 108A-25(b);*
Eff. February 1, 1976;
Readopted Eff. October 31, 1977;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015.

10A NCAC 22B .0202 FORMS

All forms are available through the private contractor mentioned in 10A NCAC 22A .0101.

History Note: *Authority G.S. 108A-25(b); 108A-54; 143B-10;*
Eff. February 1, 1976;
Readopted Eff. October 31, 1977;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015.