SECTION .0300 - PROVIDER ABUSE

10A NCAC 22F .0301 DEFINITION OF PROGRAM ABUSE BY PROVIDERS

Program abuse by providers as used in this Chapter consists of incidents, services, or practices inconsistent with accepted fiscal or medical practices which cause financial loss to the Medicaid program or its beneficiaries, or which are not reasonable or which are not necessary, including:

(1) billing for care or services at a frequency or amount that is not medically necessary, as defined by 10A NCAC 25A .0201;

(2) separate billing for care and services that are:
   (a) part of an all-inclusive procedure; or
   (b) included in the daily per-diem rate;

(3) billing for care and services that are provided by an unlicensed person or person who does not meet the requirements set out in the Medicaid State Plan or Clinical Coverage Policies for the care or services, as allowed by law;

(4) failure to provide and maintain, within accepted medical standards for the community, quality of care;

(5) failure to provide and maintain within accepted medical standards for the community, as set out in 10A NCAC 25A .0201, medically necessary care and services;

(6) failure to comply with requirements of certification or failure to comply with the terms and conditions for the submission of claims set out in Rule .0104(e) of this Subchapter;

(7) abuse as defined by 42 C.F.R. 455.2, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/;

(8) cause for termination as described in 42 C.F.R. 455.101, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/;

(9) violations of State and federal Medicaid statutes, federal Medicaid regulations, the rules of this Subchapter, the State Medicaid Plan, and Medicaid Clinical Coverage policies;

(10) failure to notify the Division of Health Benefits (Division) within 30 calendar days of learning of any adverse action initiated against any required license, certification, registration, accreditation, or endorsement of the provider or any of its officers, agents, or employees;

(11) billing the Medicaid beneficiary or any other person for items and services reimbursed by the Division;

(12) discounting client accounts to a third party agent or paying a third party agent a percentage of the amount collected;

(13) failure to refund any monies received in error to the Division within 30 calendar days of discovery;

(14) failure to file mandatory reports or required disclosures with the Division within the time-frames established in federal or state statute, rule, or regulation;

(15) billing for claims that are inaccurate, incomplete, or not personally provided by the provider, its employees, or persons with whom the provider has contracted to render services, under its direction;

(16) billing for services provided at or from a site location not associated with the approved provider number, except for hospital services as set forth in 42 C.F.R. 413.65;

(17) failure to notify the Division in writing of any change in information contained in the Medicaid provider enrollment application within 30 calendar days of the event triggering the reporting obligation;

(18) failure to retain or submit to the Division upon request documentation for services billed to the Division;

(19) failure to grant the Division access to provider facilities upon the Division's request; or

(20) failure to perform services or supply goods in accordance with all requirements under Title VI of the Civil Rights Act of 1964, Section 504 of the 1973 Rehabilitation Act, the 1975 Age Discrimination Act, the 1990 Americans With Disabilities Act, Section 1557 of the Affordable Care Act, and all applicable federal and state statutes, rules, and regulations relating to the protection of human subjects of research.

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 108A-54.2; 108A-63; 42 C.F.R. Part 455;*

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