CHAPTER 45 - GENERAL PROCEDURES FOR PUBLIC HEALTH PROGRAMS

SUBCHAPTER 45A - PAYMENT PROGRAMS

SECTION .0100 - GENERAL PROVISIONS

10A NCAC 45A .0101 GENERAL

(a) The purpose of this Subchapter is to establish uniform policies and procedures for the administration of all Department of Health and Human Services' payment programs for which the Commission for Public Health has been granted rulemaking authority.

(b) In the event of conflict between the rules in this Subchapter and the rules adopted by the various payment programs, the rules of this Subchapter shall control.

(c) Persons who wish to receive rule-making notices concerning the rules in this Subchapter may send a written request to Purchase of Care Services Unit, Division of Public Health, 1907 Mail Service Center, Raleigh, NC 27699-1907.

History Note: *Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129, 130A-205;*
Eff. July 1, 1981;
Amended Eff. July 1, 1983; April 1, 1982; January 1, 1982;
Temporary Amendment Eff. August 31, 1983, for a period of 120 days to expire on December 29, 1983;
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Amended Eff. January 1, 2014; April 1, 1999; April 1, 1993, December 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015:
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10A NCAC 45A .0102 DEFINITIONS

The following definitions shall apply throughout this Subchapter:

(1) "Authorization" means agreement by a payment program to pay for a medical or dental service or appliance provided all requirements in this Subchapter are met. An authorization is sent to the provider of service and copy is sent to individual receiving the service.

(2) "Benefits" means the purchase of medical or dental care on a fee-for-service basis. "Benefits" also means the purchase of medical or dental appliances.

(3) "Department" means the Department of Health and Human Services, or its contractor.

"Inpatient services" means medical or dental care administered to a person who has been admitted to a hospital.

(5) "Outpatient services" means medical or dental care administered to a person without admission to a hospital.

(6) "Payment programs" refers to Department program activities involving the purchase of medical or dental care on a fee-for-service basis or the purchase of medical or dental appliances, either through direct payment or through contracts with local health departments, other agencies, or private institutions. Examples of payment programs include:
   (a) Early Hearing Detection and Intervention;
   (b) HIV Medications Program;
   (c) Infant Toddler Program; and
   (d) Sickle Cell Program.

(7) "Provider" means a person or entity who administers medical or dental care or furnishes medical or dental appliances under any of the payment programs.

(8) Third Party Payor for the purposes of this Subchapter means any person or entity that is or may be indirectly liable for the cost of services or appliances furnished to a patient. Third party payors include the following:
   (a) School services, including physical or occupational therapy, speech and language pathology and audiology services, and nursing services for special needs children;
   (b) Medicaid;
   (c) Medicare, Part A and Part B;

(d) Insurance;
(e) Social Services;
(f) Worker's compensation;
(h) TRICARE, formerly Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and
(i) Head Start programs.

History Note: *Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205;*
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Amended Eff. January 1, 2014; April 1, 1999; January 1, 1996; December 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.

SECTION .0200 - ELIGIBILITY DETERMINATIONS

10A NCAC 45A .0201 RESIDENCY REQUIREMENT

(a) A person must be a permanent resident of North Carolina to be eligible for benefits provided by any of the payment programs, except as provided in Paragraph (d) of this Rule.
(b) For the purposes of this Rule, all determinations of residency shall be governed by the following rules:
(1) In order to be a resident of North Carolina, a person must:
(A) live in this State, except as provided in Subparagraph (b)(6) of this Rule,
(B) pay North Carolina income tax if state income tax liability exists,
(C) have the intention of making his permanent home in this State, and
(D) intend to return to this State whenever absent.
(2) An unemancipated minor has the residence of the parent or other relative with whom he resides. If the minor does not reside with a parent or other relative, then the minor has the residence of the adult with whom he resides. Any other minor is a resident of North Carolina if he is present in the State and either of his parents are residents of North Carolina; if the residence of the minor's mother and father is not known, the minor has the residence of the place in which he is found.
(3) Migrant farmworkers and their families who are migrants as defined in 10A NCAC 39A .0102(2) are considered residents of North Carolina while present in North Carolina for employment purposes.
(4) Applicants who are citizens of other countries are considered residents of the State if they live in North Carolina and can document their intention to make North Carolina their permanent home with a visa allowing them to remain permanently or an application for a resident visa or for citizenship.
(5) Individuals in the military who were residents of other states and are stationed in North Carolina are residents of North Carolina if they have formally declared North Carolina as their residence where they intend to pay income taxes.
(6) North Carolina residents who are temporarily living in another state while attending school are for purposes of this Rule considered to be residents of North Carolina if they have not formally changed their resident status to another state.
(c) The state of residence continues until a new one is acquired. When a new state of residence is acquired, all former residences terminate.
(d) The Director of a payment program may make exceptions to the requirement of Paragraph (a) of this Rule in order to protect the public health when a communicable disease is involved.

History Note: *Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205;*
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10A NCAC 45A .0202 DETERMINATION OF FINANCIAL ELIGIBILITY

(a) A patient must meet the financial eligibility requirements of this Subchapter to be eligible for benefits provided by the payment programs. Financial eligibility shall be determined by the NC Division of Public Health Purchase of Medical Care Services Unit through application of income scales that reflect federal poverty levels. The income scales can be found at http://www.ncdhhs.gov/control/pomcs/pomcs.htm.The definition of annual net family income in Rule .0203 of this Section and the definitions of family in Rule .0204 of this Section shall be used in applying the income scales, except as provided in Paragraph (c) of this Rule.

(b) A person is financially eligible for services under the Sickle Cell Program if the annual net family income is at or below the federal poverty level in effect on July 1, the beginning of each fiscal year.

(c) A person is financially eligible for the HIV Medications Program if the gross family income is at or below 300 percent of the federal poverty level in effect on July 1, the beginning of each fiscal year, with the following exceptions:

(1) If a waiting list develops, priority for enrollment into the HIV Medications Program shall be given to those whose net family income is at or below 125 percent of the federal poverty level, and second priority to those individuals with income above 125 percent and at or below 250 percent of federal poverty guidelines; and

(2) If the HIV Medications Program's financial eligibility level is changed, all clients enrolled in the HIV Medications Program during the most recent year or at the time the eligibility level is changed shall be eligible to continue to be enrolled in and served by the HIV Medications Program even if the clients' financial status exceeds the newly-established eligibility level. The eligibility of these clients shall remain in force until:

(A) they no longer qualify for the HIV Medications Program other than for financial reasons;

(B) they no longer require the services of the HIV Medications Program;

(C) their income increases such that they have an income that exceeds the level under which they originally qualified for and enrolled into the HIV Medications Program; or

(D) they fail to comply with the rules of the HIV Medications Program.

(3) If an individual is determined to be financially eligible, pursuant to Rule .0203 of this Section, if the application for financial eligibility was received by the Department in the fourth quarter of the fiscal year, the individual shall remain financially eligible for benefits until the end of the next fiscal year unless there is a change in the individual's family size pursuant to Rule .0204 of this Section or family financial resources or expenses during that period pursuant to Rule .0203 of this Section.

The HIV Medications Program shall provide notice of changes to the financial eligibility or other eligibility requirements to interested parties within North Carolina's HIV community (e.g., persons living with HIV disease, their families and caregivers, advocates and service providers, relevant local and state agencies) via electronic or print mechanisms.

(d) A person is financially eligible for the Cancer Program if gross family income is at or below 115 percent of the federal poverty level in effect on July 1 of each year.

(e) The financial eligibility requirements of this Subchapter do not apply to:

(1) School Health Fund financial eligibility determinations performed by a local health department which has chosen to use the financial eligibility standards of the Department of Public Instruction's free lunch program;

(2) Prenatal outpatient services sponsored through Perinatal Program high risk maternity clinic reimbursement funds, 10A NCAC 43C .0300; and

(3) Diagnostic assessments for infants up to 12 months of age with sickle cell syndrome.

(f) Except as provided in Paragraphs (c) and (g) of this Rule, once an individual is determined financially eligible for payment program benefits, benefits pursuant to Rule .0203 of this Section, the individual remains financially eligible for a period of one year after the date of application for financial eligibility unless there is a change in the individual's family size pursuant to Rule .0204 of this Section or there is a change in his family's financial resources or expenses during that period. If there is a change, financial eligibility for payment program benefits must be redetermined. Financial eligibility must be redetermined by the NC Division of Public Health Purchase of Medical Care Services Unit at least once a year.

(g) If the most current financial eligibility form on file with the Department shows that the patient was financially eligible on the date an Authorization Request for payment for drugs was received, the Authorization Request shall be approved so long as the Authorization Request is received prior to the expiration of financial eligibility and the authorized service does not extend more than 30 days after the expiration of financial eligibility.

History Note: *Authority G.S. 130A-4.2; 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205;*
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Amended Eff. July 1, 1986; April 1, 1984; July 1, 1983; October 1, 1982;
Transferred and Recodified from 10 NCAC 4C .0202 Eff. April 4, 1990;
Temporary Amendment Eff. August 9, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Amended Eff. January 1, 1996; July 1, 1995; April 1, 1995; October 1, 1994;
Temporary Amendment Eff. July 1, 1997; April 1, 1997; March 1, 1997;
Amended Eff. August 1, 1998;
Temporary Amendment Eff. November 1, 2006;
Amended Eff. October 1, 2007;
Temporary Amendment Eff. October 1, 2008;
Amended Eff. January 1, 2014; August 1, 2009;
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10A NCAC 45A .0203 ANNUAL NET FAMILY INCOME

(a) Annual net family income shall be computed by subtracting the deductions allowed in Paragraph (d) of this Rule, from the gross family income as computed in Paragraph (c) of this Rule.

(b) The time period to be used as the basis for computing annual net family income is the 12-month period immediately preceding the date a patient or his representative makes application for eligibility to a particular payment program. However, if any of the family members were unemployed for at least 30 consecutive days during this 12-month period or are currently unemployed at the time the application is completed, that person's portion of the annual net family income shall be computed on the basis of income and deductions for the six month period immediately preceding the date of application plus a projection of income and deductions (excluding medical expenses) for the six month period immediately succeeding the date of application based upon the current employment or benefit situation. Medical expenses from the 12-month period immediately preceding the date of application may be deducted from income.

(c) Gross Family Income:

(1) Gross family income shall mean the combined gross cash income received by the patient's family from the following sources:
- (A) Salaries and wages;
- (B) Earnings from self-employment;
- (C) Investment income, stocks, bonds, savings account interest, rentals, and all other investment income;
- (D) Periodic trust fund payments;
- (E) Public assistance money;
- (F) Unemployment compensation;
- (G) Alimony and child support payments received;
- (H) Military allotments;
- (I) Social Security benefits;
- (J) Veteran's Administration benefits;
- (K) Retirement and pension payments;
- (L) Worker's compensation;
- (M) Educational stipends in excess of the cost of tuition and books;
- (N) Allowances paid for basic living expenses such as housing and utilities;
- (O) Supplemental security income benefits;
- (P) All other sources of cash income except those specifically excluded.

(2) Gross family income does not include:
- (A) Irregular, incidental income that a child may earn from babysitting, lawn mowing, or other similar tasks;
- (B) Proceeds from the sale of an asset;
- (C) Withdrawals from a bank account;
- (D) Gifts;
- (E) Inheritances;

(F) Life insurance proceeds or other one time insurance settlements.

(d) Any of the following expenses which are paid or incurred by a member of the patient's family shall be allowed as deductions in determining annual net family income:

(1) state, federal, and social security taxes owed on annual income (i.e. taxes withheld minus taxes refunded) and any deductions from pay required as a condition of employment such as mandatory retirement contributions;

(2) work related expenses incurred by the individual which are required by the employer as a condition of employment, but excluding the purchase or lease of an automobile, transportation to and from work, personal clothing and cleaning costs, food expenses, and all other items not required to perform the duties of employment;

(3) medical and dental expenses not covered by a third party payor, including the reasonable costs of transportation required to obtain the medical and dental services;

(4) health insurance premiums;

(5) child care expenses for any child 14 years of age and under and any handicapped child 15 years of age and over if both parents of a two parent family or a single parent work or are disabled or are out of the home attending school;

(6) expenses for the care of any family member who is physically or mentally unable to take care of himself or herself while other family members are out of the home working or attending school;

(7) child support and alimony payments paid to support someone outside of the family household; and

(8) educational expenses incurred for the purpose of managing the disability of any member of the patient's family.

History Note: *Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205;*
Eff. July 1, 1981;
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Amended Eff. January 1, 1996; October 1, 1994; December 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.

10A NCAC 45A .0204 DETERMINATION OF FAMILY SIZE

(a) For the purpose of determining eligibility for benefits provided by any of the payment programs, a patient's family shall be defined as the patient and all individuals living in the same household with the patient who are:

(1) parents, not including step-parents, of the patient, if the patient is unmarried and less than 18 years of age;

(2) siblings or half-siblings of the patient, but not step-siblings, if the siblings are unmarried and less than 18 years of age;

(3) siblings or half-siblings of the patient, but not step-siblings, if the siblings are 18 years of age or over and have no income;

(4) the spouse of the patient; and

(5) individuals related to the patient by blood, marriage, or adoption, if the individual has no income, and if no parent(s) or spouse of the individual lives in the same household and has income.

(b) Individuals who are students and are temporarily living away from their permanent home while attending school and using their home address as their permanent address are for the purposes of the Rule considered to be living in the household of the permanent home.

(c) An adopted child shall be considered the same as a biological child and an adoptive parent shall be considered the same as a biological parent.

(d) For the purpose of this Rule, a half-sibling is a child who has one biological parent in common with the patient. A step-sibling is the child of a step-parent who has no biological parent in common with the patient.

History Note: *Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205;*
Eff. July 1, 1981;
Amended Eff. May 1, 1987;
Transferred and Recodified from 10 NCAC 4C .0204 Eff. April 4, 1990;
Amended Eff. January 1, 2014;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.

SECTION .0300 - ELIGIBILITY PROCEDURES

10A NCAC 45A .0301 INCOME DOCUMENTATION

(a) Documentation of earned income of the patient's family is required before services can be authorized in the following circumstances:

(1) Whenever the applicant is requesting payment program benefits for inpatient services, even when outpatient services have been previously authorized.

(2) Whenever medical expense deductions from income exceed three thousand dollars ($3,000).

(3) Whenever eligibility personnel have reason to believe information given may be inaccurate.

(4) Whenever the Department requests documentation for quality control purposes.

(b) Documentation of income is not required for patients financially eligible pursuant to Rule .0202(g) of this Subchapter.

(c) For purposes of this Rule, earned income means salaries, wages, and self-employment income.

(d) Eligibility personnel may require documentation of any component used in computing a patient's annual net family income.

(e) Notwithstanding the provisions of Subparagraph (a)(2), eligibility personnel are not required to demand documentation of information concerning the earned income of the patient's family when reimbursement for inpatient services is requested through local health department delivery funds, 10A NCAC 43C .0200 or perinatal program high risk maternity clinic reimbursement funds, 10A NCAC 43C .0300.

History Note: *Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205;*
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Amended Eff. January 1, 1996; October 1, 1994; December 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.

10A NCAC 45A .0302 AUTHORIZATIONS AND CLAIMS PROCESSING TIME FRAMES

(a) The following time frames shall apply to all payment programs:

(1) An Authorization Request must be received by the Department within one year after the date of service or it will be denied.

(2) The Department shall respond to an Authorization Request within 45 days after receipt.

(3) If the Department requests additional information, this information must be received within one year after the date of service or within 30 days after the date of the Department's request, whichever is later, or the Authorization Request will be denied.

(4) The Department shall approve or deny an Authorization Request within 45 days after receipt of all information.

(b) The following timeframes apply to claims payments:

(1) A claim for payment must be received by the Department within one year after the date of service or within 45 days after the date of authorization approval, whichever is later, or the claim will be denied. Corrections to claims and requests for payment adjustment made by the provider must be received by the Department within one year after the date of service or within 45 days after the date the claim is paid or returned for additional information, whichever is later, or the claim will be denied.

(2) If there are other third party payors, a claim must show payments by those payors or it must include copies of the denials of payment from those payors. Providers must bill other payors and wait at least six months after the date of service to receive payment or denial of payment before billing the Department. If no response has been received within six months after the date of service, the provider may bill the Department, but the claim must state the date that the other payors were billed.

(3) The Department shall pay or deny a claim within 45 days after receipt of a completed claim.

(c) Authorization Requests and claims for payment shall be submitted on forms provided by the Department Providers may download forms and the Provider Manual for Division of Public Health Payment Programs at http://www.ncdhhs.gov/control/pomcs/pomcs.htm.

History Note: *Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205;*
Eff. July 1, 1981;
Amended Eff. February 1, 1990; August 1, 1987; October 1, 1985; April 1, 1983;
Transferred and Recodified from 10 NCAC 4C .0302 Eff. April 4, 1990;
Amended Eff. January 1, 2014; April 1, 1999; January 4, 1994; February 1, 1992; December 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.

10A NCAC 45A .0303 PAYMENT LIMITATIONS

(a) Payment program payments shall be made for authorized services only when funds are available.

(b) During the last six months of the fiscal year, the State Health Director may limit payment program payments that can be authorized when the total amount of outstanding authorizations, plus the estimated authorizations for the remainder of the fiscal year, less estimated cancellations, exceeds 100 percent of the program's cash balance. The State Health Director shall rescind the limitations at the end of the fiscal year, or prior to the end of the fiscal year if sufficient funds become available to authorize full program benefits for the remainder of the fiscal year.

(c) Payment program benefits shall be available only for services or appliances which are not covered by another third party payor or which cannot be paid for out of funds received in settlement of a civil claim. Patients shall be advised to apply for Medicaid or Medicare benefits to which they may be entitled. However, Early Intervention Program payment shall be available for services based on Title 34, Code of Federal Regulations, Part 303.520, which is hereby incorporated by reference along with all subsequent amendments and editions. A copy of 34 C.F.R. Part 303.520 is available for inspection at the Department of Health and Human Services, Division of Public Health, Women's and Children's Health Section, Early Intervention Branch, 5605 Six Forks Road, Raleigh, North Carolina. Copies of 34 C.F.R. Part 303.520 may be downloaded and printed from the Internet at http://www.gpo.gov/fdsys/pkg/FR-2011-09-28/pdf/2011-22783.pdf. Providers shall take reasonable measures to collect other third party payments.

(d) The Department shall not pay Medicaid co-payments or in any other way supplement Medicaid payments for the services governed by this Subchapter.

(e) If prior to the Department's payment for particular services or appliances, the provider, the patient, or a person responsible for the patient receives partial or total payment for the services or appliances from a third party payor, or receives funds in settlement of a civil claim, the Department shall pay only the amount, if any, by which the Department's payment rate exceeds the amount received by the person. For the purpose of this Rule the Department's payment rate means the rate of reimbursement established in 10A NCAC 45A .0400.

(f) If after the Department makes payment for particular services or appliances, the provider, the patient, or a person responsible for the patient receives partial or total payment for the services or appliances from a third party payor, or receives funds in settlement of a civil claim which are available to pay for the services or appliances, the person receiving the payment shall reimburse the Department to the extent of the amount received by the person without exceeding the amount of the Department's prior payment to the provider. This reimbursement shall be made to the Department within 45 days after receipt of the third party payment.

(g) If the Department requests a refund of a payment made to a provider, the refund shall be made to the Department within 45 days after the date of the refund request.

History Note: *Authority G.S. 130A-5(3); 130A-27; 130A-124; 130A-127; 130A-129; 130A-205;*
Eff. July 1, 1981;
Amended Eff. February 1, 1990; September 1, 1989; March 1, 1989;
Transferred and Recodified from 10 NCAC 4C .0303 Eff. April 4, 1990;
Amended Eff. January 1, 2014; June 1, 2004; April 1, 1992; February 1, 1992; May 1, 1991; February 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.

10A NCAC 45A .0304 APPEALS PROCEDURE

Appeals concerning the interpretation and enforcement of the rules in this Section shall be made in accordance with G.S. 150B.

History Note: *Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-177; 130A-205;*
Eff. February 1, 1987;
Transferred and Recodified from 10 NCAC 4C .0305 Eff. April 4, 1990;
Amended Eff. December 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.

10A NCAC 45A .0305 DISQUALIFICATION

(a) A provider shall be disqualified from all Department payment programs upon disqualification from Medicaid, Medicare, or the Child Health Services Block Grant Program (Title V of the Social Security Act).
(b) The period of disqualification shall be equal to the period specified by the federal government for disqualification from Medicaid, Medicare, or the Child Health Services Block Grant Program (Title V of the Social Security Act).
(c) Written notification of disqualification from Department payment programs shall be given to the provider. The notification shall inform the provider of the provider's right to appeal the disqualification.
(d) Authorizations for services provided prior to the date of disqualification from Department programs shall be honored by the Department. Authorizations for services which have not been provided prior to disqualification shall be cancelled unless the provider has made a financial commitment based upon the authorization.

History Note: *Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-177; 130A-205;*
Eff. March 1, 1989;
Transferred and Recodified from 10 NCAC 4C .0306 Eff. April 4, 1990;
Amended Eff. December 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.

SECTION .0400 - REIMBURSEMENT

10A NCAC 45A .0401 GENERAL

(a) The purpose of this Section is to establish rates of reimbursement for services provided under the Department's payment programs and governed by the Commission for Public Health.
(b) The reimbursement rates established in the rules of this Section shall not apply to perinatal program high risk maternity clinic reimbursement funds, as set forth in 10A NCAC 43C .0300, or school health funds, as set forth in 10A NCAC 43E .0100. Rates of reimbursement for these programs are individually negotiated with providers by the Department's contractor, usually a local health department. These rates shall be negotiated and established in accordance with guidelines found in the respective program rules, and shall not exceed the Medicaid rate of reimbursement in effect on the date of service.

History Note: *Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205;*
Eff. October 1, 1982;
Amended Eff. July 1, 1983;
Transferred and Recodified from 10 NCAC 4C .0401 Eff. April 4, 1990;
Amended Eff. January 1, 2014; December 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.

10A NCAC 45A .0402 REIMBURSEMENT FOR INPATIENT HOSPITALIZATION

(a) The Department shall reimburse providers of authorized inpatient services for payment programs governed by Commission for Public Health at the Medicaid rate in effect on the date of service.
(b) In addition to the requirements of Paragraph (a) of this Rule, in the Cancer Program there shall be a limit on the payment for an inpatient admission of one percent of the program's current annual budget.

History Note: *Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205; 130A-223;*

Eff. October 1, 1982;
Temporary Amendment Eff. August 31, 1983, for a Period of 120 Days to Expire on December 29, 1983;
Amended Eff. May 1, 1987; July 1, 1986; January 1, 1985;
Transferred and Recodified from 10 NCAC 4C .0402 Eff. April 4, 1990;
Amended Eff. February 1, 1992; December 1, 1990;
Temporary Amendment Eff. July 6, 1992 for a Period of 180 Days or Until the Permanent Rule is Effective, Whichever is Sooner;
Amended Eff. April 1, 1999; July 1, 1995; October 1, 1992;
Temporary Amendment Eff. August 23, 1999;
Amended Eff. January 1, 2014; August 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.

10A NCAC 45A .0403 REIMBURSEMENT FOR PROFESSIONAL, OUTPATIENT, OTHER SERVICES

(a) The Department shall reimburse providers of authorized outpatient services, professional services, and all other services for payment programs governed by the Commission for Public Health not otherwise covered in the rules of this Section at the Medicaid rate in effect on the date of service.

(b) In addition to the reimbursement rate in Paragraph (a) of this Rule, for professional and outpatient services under the Cancer Program, there shall be a per claim payment limit of one percent of the program's current annual budget.

History Note: *Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205; 130A-223;*
Eff. February 1, 1976;
Amended Eff. April 22, 1977;
Readopted Eff. December 5, 1977;
Amended Eff. July 1, 1982; January 1, 1982;
Temporary Amendment Eff. November 7, 1983, for a period of 120 days to expire on March 4, 1984;
Amended Eff. October 1, 1984; March 1, 1984;
Temporary Amendment Eff. October 14, 1988, for a period of 180 days to expire on April 12, 1989;
Temporary Amendment Expired April 12, 1989;
Amended Eff. September 1, 1990;
Temporary Amendment Eff. June 19, 1996;
Temporary Amendment Expired March 11, 1997;
Amended Eff. January 1, 2014; August 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.

10A NCAC 45A .0404 REIMBURSEMENT RATES FOR SERVICES NOT COVERED BY MEDICAID

(a) The Department shall reimburse providers of authorized mobility systems (including components and accessories), environmental control units, and custom seating systems for which there are no Medicaid reimbursement rates at the manufacturer's catalog price less five percent.

(b) The Department shall reimburse providers of authorized prosthetics and orthotics at the Medicare rate of reimbursement when there is no Medicaid rate of reimbursement for the item. When there is neither a Medicaid rate nor a Medicare rate for the item, the Department shall reimburse at the provider's usual charge to the general public.

(c) The Department shall reimburse providers of authorized equipment repair services for which there are no Medicaid reimbursement rates at forty five dollars ($45.00) per hour.

(d) The Department shall reimburse physicians and dentists for authorized services for which there are no Medicaid rates at the Medicaid rate for a comparable procedure as determined by the program's medical director or at 80 percent of the amount billed, whichever is less.

(e) The Department shall reimburse providers of authorized assistive listening devices and those types of hearing aids for which there are no Medicaid rates at invoice cost plus the Medicaid dispensing fee for a new hearing aid(s).

(f) The Department shall reimburse providers of authorized amplification-related services for which there are no Medicaid rates at the rates paid for audiology services under Medicaid's Independent Practitioner Program.

(g) The Department shall reimburse providers of authorized services not otherwise specified in this Section, for which there are no Medicaid reimbursement rates, at the provider's usual charge to the general public.

History Note: *Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205;*
Eff. October 1, 1982;
Transferred and Recodified from 10 NCAC 4C .0404 Eff. April 4, 1990;
Amended Eff. December 1, 1990;
RRC Objection Eff. November 17, 1994 due to lack of statutory authority;
Amended Eff. January 1, 2014; April 1, 1999; October 1, 1995; February 1, 1995;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.

10A NCAC 45A .0405 BILLING THE PATIENT PROHIBITED

If a provider has accepted partial or total payment from the Department for particular services, the Department's reimbursement rate for those services shall be considered payment in full for those authorized services for all payment programs and the provider shall not bill the patient or his family for any amount exceeding the payment received.

History Note: *Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205;*
Eff. October 1, 1982;
Transferred and Recodified from 10 NCAC 4C .0405 Eff. April 4, 1990;
Amended Eff. January 1, 2014; April 1, 1995; December 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.

SECTION .0500 - QUALITY CONTROL

10A NCAC 45A .0501 GENERAL

The Department screens, reviews and investigates financial eligibility forms in an effort to detect cases where the form contains incorrect information. If the incorrect information is found before any services are authorized based on that financial eligibility form, the Department shall make further investigations before authorizing services. If services have already been authorized based on a financial eligibility form that contains incorrect information that materially affects the person's financial eligibility, the Department may take steps to terminate financial eligibility.

History Note: *Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-177; 130A-205;*
Eff. October 1, 1983;
Transferred and Recodified from 10 NCAC 4C .0501 Eff. April 4, 1990;
Amended Eff. December 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.

10A NCAC 45A .0502 TERMINATION OF ELIGIBILITY

The Department shall take the following steps in order to terminate a person's eligibility for program benefits which is based on incorrect information or information that has changed since the eligibility applications were completed:

(1) Notice shall be given to the applicant and the eligibility interviewer that:
   (a) the Department has determined that eligibility was established based on incorrect information or information that has changed since the program eligibility applications were completed,
   (b) the applicant is not eligible for program benefits, and
   (c) the Department has made a tentative decision to terminate eligibility.

(2) The applicant shall be given 30 days from the date of the notice of tentative decision to terminate eligibility to provide additional information or to file an appeal. If the applicant does not appeal or submit written information which proves that he is eligible, eligibility for program benefits shall be terminated. The applicant may reapply for eligibility at any time if there is a change in family size, income, deductions, or residency status.

History Note: *Authority G.S. 130A-5(3); 130A-24(a1); 130A-124; 130A-127; 130A-129; 130A-205;*
Eff. October 1, 1983;
Transferred and Recodified from 10 NCAC 4C .0502 Eff. April 4, 1990.
Amended Eff. October 1, 1994; December 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.

10A NCAC 45A .0503 EFFECT ON AUTHORIZATIONS AND AUTHORIZATION REQUESTS

(a) All authorizations will be honored by the Department, except that an authorization may be cancelled after a final decision to terminate eligibility if:

(1) The applicant and the provider are notified of the authorization cancellation prior to the provision of the service. Authorizations may be cancelled in part when only some of the services have been provided; and

(2) The provider has not made financial commitments based upon the authorization.

(b) Authorization requests received during the period of time that the eligibility is under review or is being appealed will be held until a final decision in the matter is made.

History Note: *Authority G.S. 130A-5(3); 130A-24(a1); 130A-124; 130A-127; 130A-205; 143B-193;*
Eff. October 1, 1983;
Transferred and Recodified from 10 NCAC 4C .0503 Eff. April 4, 1990;
Amended Eff. October 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 13, 2015.