

## 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. These rules are intended to facilitate efficient financial eligibility and payment mechanisms with a mutual goal of the Department and the providers to render appropriate services to eligible patients.

(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 will control.

(c) The rules of this Subchapter shall not apply to the North Carolina Hemophilia Assistance Plan, 10A NCAC 43F .1100 or to the Home Health Program, 10A NCAC 39A .0200.

(d) Persons who wish to receive rule-making notices concerning the rules in this Subchapter must submit a written request to Office of the Controller, Department of Health and Human Services, 1904 Mail Service Center, Raleigh, NC 27699-1904. The request must specify the calendar year during which the person wishes to receive the notices. A check for ten dollars (\$10.00) made payable to the N.C. Department of Health and Human Services must be enclosed with each request to cover the cost of printing and mailing the notices for the year specified. The fee is non-refundable if there are no notices during the year.

*History Note: Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129, 130A-205; 150B-21.2(b); 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; Amended Eff. December 29, 1983; Transferred and Recodified from 10 NCAC 4C .0101 Eff. April 4, 1990; Amended Eff. April 1, 1999; April 1, 1993, December 1, 1990.*

##### 10A NCAC 45A .0102 DEFINITIONS

The following definitions shall apply throughout this Subchapter:

- (1) "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.
- (2) "Department" means the Department of Health and Human Services, or its contractor.
- (3) "Inpatient services" means medical or dental care administered to a person who has been admitted to a hospital.
- (4) "Outpatient services" means medical or dental care administered without admission to a hospital.
- (5) "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. These activities are administered in the following:
  - (a) Children's Special Health Services,
  - (b) Cancer Program,
  - (c) Kidney Program,
  - (d) Maternal and Child Health Program,
  - (e) Migrant Health Program,
  - (f) School Health Fund,
  - (g) Sickle Cell Program,
  - (h) HIV Medications Program, and
  - (i) Adult Cystic Fibrosis Program.
- (6) "Provider" means a person or entity who administers medical or dental care or furnishes medical or dental appliances under any of the payment programs.
- (7) "Authorization" means agreement by a payment program to pay for a medical or dental service or appliance provided all requirements in 10A NCAC 45A are met.

*History Note: Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-177; 130A-205; Eff. July 1, 1981; Amended Eff. July 1, 1986; January 1, 1982; Transferred and Recodified from 10 NCAC 4C .0102 Eff. April 4, 1990; Amended Eff. April 1, 1999; January 1, 1996; December 1, 1990.*

## 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; Eff. July 1, 1981; Transferred and Recodified from 10 NCAC 4C .0201 Eff. April 4, 1990; Amended Eff. October 1, 1994; December 1, 1990.*

**Note from the Codifier:** The OAH website includes notices and the text of proposed temporary rules as required by G.S. 150B-21.1(a1). Prior to the agency adopting the temporary rule, the agency must hold a public hearing no less than five days after the rule and notice have been published and must accept comments for at least 15 business days.

For questions, you may contact either the Office of Administrative Hearings at 919.733.2678, email [oah.postmaster@ncmail.net](mailto:oah.postmaster@ncmail.net) or the Rules Review Commission at 919.733.2721.

## TITLE 10A – DEPARTMENT OF HEALTH AND HUMAN SERVICES

**Rulemaking Agency:** *Commission for Public Health*

**Codifier of Rules received for publication the following notice and proposed temporary rule(s) on: July 24, 2008**

**Rule Citations:** 10A NCAC 45A .0202

**Public Hearing:**

**Date:** August 12, 2008

**Time:** 3:00 p.m.

**Location:** Cardinal Room, 5605 Six Forks Road, Raleigh, NC

**Reason:** Legislative approval of the DHHS budget, which was effective July 16, 2008, authorized expansion of financial eligibility for the department's HIV Medications Program to 300%. This temporary rule change makes this legislated expansion of coverage possible, and it will be followed by a permanent version of the same rules change. The adoption of this change as a temporary rule will enable newly – eligible HIV patients to receive life-saving medications as soon as legally possible.

**Comment Procedures:** Comments from the public shall be directed to: Chris G. Hoke, JD, 1915 Mail Service Center, Raleigh, NC 27699-1915, phone (919) 707-5006, email Chris.Hoke@ncmail.net. The comment period begins July 28, 2008 and ends August 18, 2008.

## **CHAPTER 45 - GENERAL PROCEDURES FOR PUBLIC HEALTH PROGRAMS**

### **SUBCHAPTER 45A - PAYMENT PROGRAMS**

#### **SECTION .0200 - ELIGIBILITY DETERMINATIONS**

##### **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 through application of income scales. The definition of annual net income in Rule .0203 of this Subchapter and the definitions of family in Rule .0204 of this Subchapter shall be used in applying the income scales, except as provided in Paragraphs (c), (e) and (f) of this Rule.

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

- (1) If a waiting list develops, priority for enrollment into the 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) At any time that the Program's financial eligibility level is changed, all clients enrolled in the 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 Program. This shall be true even if the clients' financial status at that time places them above the newly-established level. The eligibility of these clients shall remain in force until:
  - (A) they no longer qualify for the Program other than for financial reasons; or
  - (B) they no longer require the services of the Program; or
  - (C) their income increases such that they have an income that exceeds the level under which they originally qualified for and enrolled into the Program; or
  - (D) they fail to comply with the rules of the Program.

Changes related to the Program's financial eligibility level or status shall be communicated 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) by the Program via electronic or print mechanisms.

(d) A person is financially eligible for the Kidney Program if the net family income is at or below the following scale:

- Family Size 1: \$6,400;
- Family Size 2: \$8,000;
- Family Size 3: \$9,600;
- Family Size 4: \$11,000;

Family Size 5: \$12,000;

Family Size 6 and over: add \$800 per family member.

- (e) 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.
- (f) A child is financially eligible for Children's Special Health Services if the child is approved for Medicaid when applying or reapplying for program coverage, except for children eligible under Paragraph (g) and (h) of this Rule.
- (g) A child approved for Children's Special Health Services post adoption coverage pursuant to 10A NCAC 43F .0800, is eligible for services under Children's Special Health Services if the child's net income is at or below the federal poverty level in effect on July 1 of each year.
- (h) A person is financially eligible for services under the Adult Cystic Fibrosis Program if the net family income is at or below the federal poverty level in effect on July 1 of each year.
- (i) The financial eligibility requirements of this Subchapter do not apply to:
  - (1) Migrant Health Program;
  - (2) 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;
  - (3) Prenatal outpatient services sponsored through local health department delivery funds, 10A NCAC 43C .0200; or through Perinatal Program high risk maternity clinic reimbursement funds, 10A NCAC 43C .0300; and
  - (4) Diagnostic assessments for infants up to 12 months of age with sickle cell syndrome.
- (j) Except as provided in Paragraphs (k) and (l) of this Rule, once an individual is determined financially eligible for payment program benefits, 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 Subchapter or 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 at least once a year.
- (k) For purposes of the Kidney Program and HIV Medications Program, once an individual is determined to be financially eligible, if the application for financial eligibility was received by the Department in the fourth quarter of the fiscal year, the individual remains 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 Subchapter or his family's financial resources or expenses during that period.
- (l) Children eligible for Children's Special Health Services Program benefits under Paragraph (f) of this Rule are financially eligible for a service if they were Medicaid eligible on the date the requested service was initiated.
- (m) 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 less than 30 days prior to the expiration of financial eligibility and the authorized service does not extend more than 30 days after the expiration of financial eligibility.

*Authority G.S. 130A-4.2; 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205.*

#### **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; Amended Eff. March 1, 1989; May 1, 1987; April 1, 1982; Transferred and Recodified from 10 NCAC 4C .0203 Eff. April 4, 1990; Amended Eff. January 1, 1996; October 1, 1994; December 1, 1990.*

#### **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 are for the purposes of the Rule considered to be living in the household of the permanent home.
- (c) An adopted child who has received approval for Children's Special Health Services support pursuant to 10A NCAC 43F .0800 shall be considered a family of one for purposes of this Rule.
- (d) Except as provided in Paragraph (c) of this Rule, 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.
- (e) 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-177; 130A-205;  
 Eff. July 1, 1981;  
 Amended Eff. May 1, 1987;  
 Transferred and Recodified from 10 NCAC 4C .0204 Eff. April 4, 1990.

## **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;  
 Eff. July 1, 1981;  
 Amended Eff. July 1, 1983; April 1, 1982; January 1, 1982;  
 Transferred and Recodified from 10 NCAC 4C .0301 Eff. April 4, 1990;  
 Amended Eff. January 1, 1996; October 1, 1994; December 1, 1990.

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

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, except in the Migrant Health Program where authorizations are not used.
- (2) The Department shall respond to an Authorization Request within 45 days after receipt.
- (3) If additional information is requested, 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 necessary information.
- (5) 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 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.
- (6) 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. Providers of pharmacy outpatient services are required to bill Medicaid. However, they are not required to bill other third party payors and wait six months before billing the Department but are required to refund the Department if other third party payments are received.
- (7) The Department shall pay or deny a claim within 45 days after receipt of a completed claim.
- (8) Authorization Requests and claims for payment shall be submitted on forms approved by the Department.

*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. April 1, 1999; January 4, 1994; February 1, 1992; December 1, 1990.

#### **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 benefits 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. The Director of the Office of Research, Demonstrations, and Rural Health Development may limit payment program benefits for the Migrant Health Program when the cost of the services is projected to surpass the program's cash balance within the fiscal year. The Director of the Office of Research, Demonstrations, and Rural Health Development shall rescind the limitations if sufficient funds become available to reimburse for program benefits for the Migrant Health Program.
- (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 apply for Medicaid or Medicare benefits to which they may be entitled. However, payment program benefits shall be available for Children's Special Health Services sponsored clinic patients who cannot reasonably be examined or treated by a Medicaid provider or an authorized provider for another third party payor because of transportation problems, a need for emergency care, or similar exceptional situations. All exceptions must be approved by the Children's Special Health Services program's medical director. Also, Children's Special Health Services may make payments for services provided to Medicaid patients when acting as a Medicaid provider under an agreement making the program eligible for reimbursement from Medicaid. Providers shall take reasonable measures to collect other third party payments. For the purposes of this Subchapter, third party payor 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:
  - (1) School services, including physical or occupational therapy, speech and language pathology and audiology services, and nursing services for special needs children;
  - (2) Medicaid;
  - (3) Medicare, Part A and Part B;
  - (4) Insurance;
  - (5) Social Services;
  - (6) Worker's compensation;
  - (7) CHAMPUS; and
  - (8) Head Start programs.

- (d) The Department shall not pay Medicaid co-payments or in any other way supplement Medicaid payments.
- (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) Notwithstanding Paragraph (e) of this Rule, when the provider, the patient or a person responsible for the patient receives other third party payments equal to or exceeding the Department's payment rate, the Department shall pay the difference between the other third party payments and the provider's charge for an adopted child that meets the requirements of 10A NCAC 43F .0801. The Department's payment shall not exceed the payment rate in Section .0400 of the Subchapter.
- (g) 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.
- (h) Notwithstanding Paragraph (g) of this Rule, if after the Department makes payment for particular services or appliances for an adopted child that meets the requirements of 10A NCAC 43F .0801, the provider receives partial or total payment from a third party payor, the provider shall only be required to reimburse the Department the amount by which the total of payments exceeds the provider's charge.
- (i) 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-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. June 1, 2004; April 1, 1992; February 1, 1992; May 1, 1991; February 1, 1991.

#### **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.

#### **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.

### **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.

(b) The reimbursement rates established in the rules of this Section shall not apply to local health department delivery funds, 10A NCAC 43C .0200, perinatal program high risk maternity clinic reimbursement funds, 10A NCAC 43C .0300, or school health funds, 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 at the time the claim is received by the Department.

*History Note: Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-177; 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. December 1, 1990.*

#### **10A NCAC 45A .0402 REIMBURSEMENT FOR INPATIENT HOSPITALIZATION**

(a) The Department shall reimburse providers of authorized inpatient hospitalization services at 80 percent of the hospital's inpatient cost rate, which is then applied to the amount billed for authorized services. The inpatient cost rate is a ratio of cost to charges that is derived from audited cost reports and is obtained from the Division of Medical Assistance. The Department shall use the cost rate in effect on the date a claim is received, and retroactive adjustments to claims paid shall not be made. If a cost rate cannot be obtained for an out-of-state hospital, the Department shall reimburse the hospital at 75 percent of the billed amount for authorized services. The cost rates and any subsequent amendments and editions are incorporated herein by reference in accordance with G.S. 150B-21.6. The cost rates can be obtained from the Office of the Controller, Department of Health and Human Services, 1904 Mail Service Center, Raleigh, NC 27699-1904.

(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 1 percent of the program's current annual budget.

*History Note: Filed as a Temporary Amendment Eff. July 6, 1992 for a Period of 180 Days or Until the Permanent Rule is Effective, Whichever is Sooner; Filed as a Temporary Amendment Eff. August 31, 1983, for a Period of 120 Days to Expire on December 29, 1983; Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205; 130A-223; Eff. October 1, 1982; 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. April 1, 1999; July 1, 1995; October 1, 1992; February 1, 1992; December 1, 1990; Temporary Amendment Eff. August 23, 1999; Amended Eff. August 1, 2000.*

#### **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 not otherwise covered in the rules of this Section at the Medicaid rate in effect at the time the claim is received by the Department, except in the Migrant Health Program.

(b) The Migrant Health Program shall reimburse providers of program covered outpatient, professional, and other services at the Medicaid rate in effect at the time the claim is received minus the allowable patient copayment to a maximum program payment of one hundred fifty dollars (\$150.00) per claim, per date of service. The allowable patient copayment is six dollars (\$6.00) per claim for each prescribed drug and supply, six dollars (\$6.00) per claim for all durable medical equipment, and five dollars (\$5.00) per claim, per date of service for all other services. The one hundred fifty dollar (\$150.00) limit shall not apply to drugs, supplies, and durable medical equipment.

(c) In addition to the requirements of 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. October 1, 1982;*  
*Amended Eff. July 1, 1983;*  
*Transferred and Recodified from 10 NCAC 4C .0403 Eff. April 4, 1990;*  
*Amended Eff. 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; April 1, 1995; October 1, 1992;*  
*Temporary Amendment Eff. August 23, 1999;*  
*Amended Eff. October 1, 2006; June 1, 2004; August 1, 2000.*

#### **10A NCAC 45A .0404 REIMBURSEMENT 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.
- (h) The Department shall reimburse providers under the Migrant Health Program at the rates specified in this rule. Services do not have to first be authorized; however, reimbursement is contingent upon client eligibility, the provision of services covered by the program, and availability of funds.

*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. April 1, 1999; October 1, 1995; February 1, 1995.*

#### **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 except the Maternal and Child Health Program Delivery Fund, the School Health Fund, and the Migrant Health Program. A provider who has accepted partial or total payment from the Department under the Maternal and Child Health Delivery Fund or the School Health Fund shall not bill the patient or his family for any amount greater than the amount by which the Medicaid rate exceeds the Department's payment for the particular services. A provider who has accepted payment from the Department under the Migrant Health Program may bill the patient for copayments established in this Section.

*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. April 1, 1995; December 1, 1990.*

### **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.*

### **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.*

### **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.*