SUBCHAPTER 22F - PROGRAM INTEGRITY

SECTION .0100 - GENERAL

10A NCAC 22F .0101 SCOPE

This Subchapter shall provide methods and procedures to ensure the integrity of the Medicaid program. Nothing in these procedures is intended, nor shall be construed, to grant any provider any right to participate in the Medicaid program not granted by federal law or regulations.

History Note: *Authority G.S. 108A-25(b); 108A-63; 108A-64; 42 C.F.R. 455.1;*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1990; May 1, 1984;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015.

10A NCAC 22F .0102 ORGANIZATION

The North Carolina Department of Health and Human Services, Division of Health Benefits shall perform the duties required by this Subchapter. The Department or Division may enter into contracts with other persons for the purpose of performing these duties.

History Note: *Authority G.S. 108A-25(b); 42 C.F.R. Part 455;*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1984;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;
Amended Eff. March 1, 2020.

10A NCAC 22F .0103 FUNCTIONS

(a) The Division shall develop, implement and maintain methods and procedures for preventing, detecting, investigating, reviewing, hearing, referring, reporting, and disposing of cases involving fraud, abuse, error, overutilization or the use of medically unnecessary or medically inappropriate services.

(b) The Division shall institute methods and procedures to:

(1) receive and process complaints and allegations of provider and recipient aberrant practices;
(2) perform preliminary and full investigations to collect facts, data, and information;
(3) analyze and evaluate data and information to establish facts and conclusions concerning provider and recipient practices;
(4) make administrative decisions affecting providers, including but not limited to suspension from the Medicaid program;
(5) recoup improperly paid claims;
(6) establish remedial measures including but not limited to monitoring programs;
(7) conduct administrative review or, when legally necessary, hearings except as provided in Subparagraph (b)(8) of this Rule;
(8) refer for provider peer review those cases involving questions of professional practice.

History Note: *Authority G.S. 108A-25(b); 108A-63; 108A-64; 42 C.F.R. 455, Subpart A;*
Eff. May 1, 1984;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015.

10A NCAC 22F .0104 PREVENTION

(a) Provider Education. Upon the request of a provider, the Division may conduct on-site educational visits to assist a provider in complying with requirements of the Medicaid Program.

(b) Provider Manuals. The Division shall prepare and make available a provider manual containing at least the following information:

(1) amount, duration, and scope of assistance;
(2) participation standards;
(3) penalties;
(4) reimbursement rules; and
(5) claims filing instructions.

(c) Prepayment Claims Review. The Division shall check eligibility, duplicate payments, third party liability, and unauthorized or uncovered services by means of prepayment review, computer edits and audits, and investigation.

(d) Prior Approval. The Division shall require prior approval for certain specified covered services as set forth in the Medicaid State Plan.

(e) Claims. The following terms and conditions shall apply to the submission of claims:

(1) Medicaid payment shall constitute payment in full;
(2) charges to Medicaid recipients for the same items and services shall not be higher than for private paying patients;
(3) the provider shall keep all records as necessary to support the services claimed for reimbursement;
(4) the provider shall disclose the contents of his Medicaid financial and medical records to the Division and its agents; and
(5) Medicaid reimbursement shall only be made for medically necessary care and services as defined in 10A NCAC 25A .0201.

(f) Provider Administrative Participation Agreements. All providers shall execute a written participation agreement as a condition for participating in the N.C. State Medicaid Program.

(g) The Recipient Management LOCK-IN System. The Division shall establish a lock-in system to control recipient overutilization of provider services. A lock-in system restricts an overutilizing recipient to the use of one physician and one pharmacy, of the recipient's choice, provided the recipient's physician is able to refer the recipient to other physicians as medically necessary, as defined in 10A NCAC 25A .0201.

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 108A-63; 108A-64; 108C; 42 C.F.R. Part 455; 42 CFR 455.23; 42 C.F.R. 447.15;*
Eff. May 1, 1984;
Readopted Eff. September 1, 2018.

10A NCAC 22F .0105 DETECTION

History Note: *Authority G.S. 108A-25(b); 108A-63; 108A-64; 42 C.F.R. Part 455; 42 C.F.R. 455.12–23;*
Eff. May 1, 1984;
Repealed Eff. July 1, 2018.

10A NCAC 22F .0106 CONFIDENTIALITY

All investigations by the Division concerning allegations of provider fraud, abuse, over-utilization, or inadequate quality of care shall be confidential, and the information contained in the files of such investigations shall be confidential, except as permitted by State or Federal law or regulation.

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 132-1.4; 42 C.F.R. Part 455; 42 C.F.R. 455.21;*
Eff. May 1, 1984;
Amended Eff. May 1, 1990;
Readopted Eff. July 1, 2018.

10A NCAC 22F .0107 RECORD RETENTION

All Title XIX and Title XXI providers shall keep and maintain all Medicaid and NC Health Choice financial, medical, or other records necessary to disclose the nature and extent of services furnished to Medicaid and NC Health Choice recipients and claimed for reimbursement. These records shall be retained for a period of not less than five full years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or data retention agreements. Upon notification of an audit or upon receipt of a request for records, all records related to the audit or records request shall be retained until notification that the investigation has been concluded.

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-63; 108A-64; 42 C.F.R. Part 455; 42 C.F.R. 455.12–23; 42 C.F.R. 431.107;*
Eff. April 1, 1988;
Readopted Eff. July 1, 2018.

SECTION .0200 - PROVIDER FRAUD AND PHYSICAL ABUSE OF RECIPIENTS

10A NCAC 22F .0201 DEFINITION OF PROVIDER FRAUD

History Note: *Authority G.S. 108A-25(b); 108A-63; 150B-21.6; 42 U.S.C. 1396(b) et seq.; 42 C.F.R. Part 455;*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1990; May 1, 1984;
Repealed Eff. July 1, 2018.

10A NCAC 22F .0202 INVESTIGATION

(a) The Division shall conduct a preliminary investigation of all complaints received or allegations of fraud, waste, abuse, error, or practices not conforming to state and federal Medicaid laws and regulations, clinical coverage policies, or the Medicaid State Plan until it is determined:

(1) whether there are sufficient findings to warrant a full investigation, as set out in Paragraph (b) of this Rule;
(2) whether there is sufficient evidence to warrant referring the case for civil fraud investigation, criminal fraud investigation, or both; or
(3) whether there is insufficient evidence to support the allegation(s) and the case may be closed.

(b) There shall be a full investigation if the preliminary findings support a credible allegation of possible fraud until:

(1) the case is found to be one of program abuse subject to administrative action, pursuant to Rule .0602 of this Subchapter;
(2) the case is closed for insufficient evidence of fraud or abuse; or
(3) the provider is found not to have abused or defrauded the program.

History Note: *Authority G.S. 108A-25(b); 108A-63; 42 U.S.C. 1396(b) et seq.; 42 C.F.R. Part 455, Subpart A;*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1984;
Readopted Eff. July 1, 2018.

10A NCAC 22F .0203 REFERRAL TO LAW ENFORCEMENT AGENCY

The Division shall refer credible allegations of provider fraud, defined as provided 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/, or suspected physical abuse of recipients to the State Medicaid Fraud Control Unit or other law enforcement agency.

History Note: *Authority G.S. 108A-25(b); 108A-63; P.L. 95-142; 42 C.F.R. 455.2; 42 C.F.R. 455.14; 42 C.F.R. 455.15;*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1984;
Readopted Eff. July 1, 2018.

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;*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1984;
Readopted Eff. June 15, 2020.

10A NCAC 22F .0302 INVESTIGATION

(a) Fraud, waste, abuse, error, or practices not conforming to state and federal Medicaid laws and regulations, clinical coverage policies, or the Medicaid State Plan shall be investigated according to the provisions of Rule .0202 of this Subchapter.
(b) A Provider Summary Report shall be prepared by the Division furnishing the full investigative findings of fact, conclusions, and recommendations.
(c) The Division shall review the findings, conclusions, and recommendations and make a tentative decision for disposition of the case. The Division shall seek full restitution of any improper provider payments as required by 10A NCAC 22F .0601. In addition, upon determination that program abuse has occurred and based on the factors set out in Rule .0602(b) of this Subchapter, the Division may also take one or more administrative actions pursuant to Rule .0602 of this Subchapter.
(d) The tentative decision shall be subject to the review procedures described in Section .0400 of this Subchapter.
(e) If the investigative findings show that the provider is not licensed or certified as required by federal and State law, then the provider shall not participate in the North Carolina State Medical Assistance Program (Medicaid). The Division is required to verify provider licensure pursuant to 42 C.F.R. 455.412, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/.

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 108A-63; 108C-5; 108C-7; 42 C.F.R. 455, Subpart A; 42 CFR 455.412;*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1988; May 1, 1984;
Readopted Eff. September 1, 2018.

SECTION .0400 – AGENCY RECONSIDERATION REVIEW

10A NCAC 22F .0401 PURPOSE

History Note: *Authority G.S. 108A-25(b); 42 C.F.R. 456;*
Eff. December 1, 1982;
Transferred and Recodified from 10 NCAC 26I .0201 Eff. July 1, 1995;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;
Repealed Eff. July 1, 2018.

10A NCAC 22F .0402 RECONSIDERATION REVIEW FOR PROGRAM ABUSE

(a) The Division shall notify the provider in writing by certified mail of the tentative decision made pursuant to Rule .0302 of this subchapter and the opportunity for a reconsideration of the tentative decision.
(b) The provider shall be instructed to submit to the Division in writing a request for a Reconsideration Review within 30 business days from the date of receipt of the notice. Failure to request a Reconsideration Review in the specified time shall result in the implementation of the tentative decision as the Division's final decision.
(c) The Notice of Reconsideration Review shall be sent to the provider within 30 business days from receipt of the request. The provider shall be notified in writing to appear at a specified day, time, and place. The provider may be accompanied by legal counsel if the provider so desires.
(d) The provider shall provide a written statement to the Hearing Unit prior to the Reconsideration Review identifying any claims that the provider wishes to dispute and setting forth the provider's specific reasons for disputing the determination on those claims.
(e) The purpose of the Reconsideration Review includes:
(1) clarification formulation, and simplification of issues;
(2) exchange and full disclosure of information and materials;
(3) review of the investigative findings;
(4) resolution of matters in controversy;
(5) consideration of mitigating and extenuating circumstances;
(6) reconsideration of the administrative measures to be imposed; and
(7) reconsideration of the restitution of overpayments.
(f) The Reconsideration Review decision shall be sent to the provider, in writing by certified mail, within 30 business days following the date the review record is closed. The review record is closed when all arguments and

documents for review have been received by the Hearing Unit. The decision shall state that the provider may request a contested case hearing in accordance with G.S. 150B, Article 3 and 26 NCAC 03 .0103. Pursuant to G.S. 150B-23(f), the provider shall have 60 days from receipt of the Reconsideration Review decision to request a contested case hearing in the Office of Administrative Hearings. Unless the request is received within the time provided, the Reconsideration Review decision shall become the Division's final decision and no further appeal shall be permitted.

History Note: *Authority G.S. 108A-25(b); 108A-54; 150B, Article 3; S.L. 2011-375, s. 2; 42 C.F.R. Part 455.512;*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
ARRC Objection October 22, 1987;
Amended Eff. November 1, 1988; March 1, 1988; May 1, 1984;
Readopted Eff. July 1, 2018.

10A NCAC 22F .0403 PROCESS

History Note: *Authority G.S. 108A-25(b); 42 C.F.R. 456;*
Eff. December 1, 1982;
Amended Eff. January 1, 1988; January 1, 1986;
Transferred and Recodified from 10 NCAC 26I .0202 Eff. July 1, 1995;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

SECTION .0500 - PEER REVIEW

10A NCAC 22F .0501 GENERAL
10A NCAC 22F .0502 PEER REVIEW ESTABLISHED
10A NCAC 22F .0503 CHOICE OF PROCEDURES
10A NCAC 22F .0504 COMPOSITION OF PEER REVIEW BOARD
10A NCAC 22F .0505 NOTICE OF PEER REVIEW

History Note: *Authority G.S. 108A-25(b); 150B-11; 42 C.F.R. Part 455; 42 C.F.R. Part 456;*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1990; January 1, 1987; January 1, 1986; May 1, 1984;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22F .0506 VENUE
10A NCAC 22F .0507 DOCUMENTATION
10A NCAC 22F .0508 PEER REVIEW PROCEDURES
10A NCAC 22F .0509 DISQUALIFICATION OF BOARD MEMBERS
10A NCAC 22F .0510 FAILURE OF PROVIDER TO ATTEND THE REVIEW

History Note: *Authority G.S. 108A-25(b); 150B-11; 42 C.F.R. Part 455; 42 C.F.R. Part 456;*
Eff. May 1, 1984;
Amended Eff. May 1, 1990; September 1, 1988; January 1, 1987;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

SECTION .0600 – ADMINISTRATIVE SANCTIONS AND RECOUPMENT

10A NCAC 22F .0601 RECOUPMENT

(a) The Division shall seek full restitution of improper payments, as defined by 42 C.F.R. 431.958, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/, made to providers by the Medicaid Program. Recovery may be by lump sum payment, by a negotiated payment schedule, or by withholding from the provider's pending claims the total or a portion of the recoupment amount.

(b) A provider may seek reconsideration review of a recoupment imposed by the division under Rule .0402 of this Subchapter.

History Note: *Authority G.S. 108A-25(b); 108C-5(g); 42 C.F.R. Part 431, Subpart Q; 42 C.F.R. Part 455, Subpart F; 42 C.F.R. Part 456;*
Eff. February 1, 1982;
Amended Eff. May 1, 1984;
Readopted Eff. July 1, 2018.

10A NCAC 22F .0602 ADMINISTRATIVE ACTIONS

(a) The following types of administrative actions may be imposed in any particular order by the Division in instances of program abuse by providers:

(1) warning letters for instances of abuse that can be settled by issuing a warning to cease the specific abuse. The letter shall state that any further violations shall result in administrative or legal action initiated by the Division;
(2) suspension of a provider from further participation in the Medicaid Program for a specified period of time, subject to appeal rights under G.S. 150B, Article 3, provided that findings have been made by the Division that this action shall not deprive recipients of access to reasonable service of adequate quality as set out in 42 C.F.R. 440.230, 440.260, and 455.23, which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/;
(3) termination of a provider from further participation in the Medicaid Program, subject to appeal rights under G.S. 150B, Article 3, provided that findings have been made by the Division that this action shall not deprive recipients of access to reasonable services of adequate quality as set out in 42 C.F.R. 440.230, 440.260, and 455.23, which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov;
(4) probation whereby a provider's participation is monitored for a specified period of time not to exceed one year, subject to appeal rights under G.S. 150B, Article 3. At the termination of the probation period the Division shall conduct a follow-up review of the provider's Medicaid practice to ensure compliance with all applicable laws, regulations, and conditions of participation in Medicaid;
(5) negotiation of a financial settlement with the provider;
(6) placing the provider on prepayment review in accordance with G.S. 108C-7; or
(7) establishing a monitoring program not to exceed one year whereby the provider shall comply with pre-established conditions of participation to allow review and evaluation of the provider's Medicaid claims.

(b) The following factors are illustrative of those to be considered in determining the kind and extent of administrative actions to be imposed:

(1) seriousness of the offense;
(2) extent of violations found;
(3) history of prior violations;
(4) prior imposition of sanctions;
(5) length of time provider practiced violations;
(6) provider willingness to obey program rules;
(7) recommendations by the investigative staff or Peer Review Committees; and
(8) effect on health care delivery in the area.

(c) When the Division has taken administrative action against a provider under Paragraphs (a)(2), (a)(3), or (a)(4) of this Rule, the Division shall notify the licensing board or other certifying group governing the sanctioned provider, federal and state agencies, and departments of social services in the counties where beneficiaries served by the provider reside of the findings made and the sanctions imposed.

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 108C-5; 108C-7; 42 C.F.R. 440.230; 42 C.F.R.*
440.260; 42 C.F.R. Part 431; 42 C.F.R. Part 455; 42 C.F.R. 455.23; 42 C.F.R. 455.101; 42 C.F.R. 1002.3;
Eff. May 1, 1984;

Amended Eff. December 1, 1995; May 1, 1990;
Readopted Eff. September 1, 2018;
Amended Eff. March 1, 2020.

10A NCAC 22F .0603 PROVIDER LOCK-OUT

(a) The Division may suspend the provider, based on the factors set out in Rule .0602(b) of this Subchapter, from participating in the Medicaid program, provided that the Division meets the requirements of 42 C.F.R. 431.54(f), which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/.

(b) Suspension or termination from participation of any provider shall preclude the provider from submitting claims for payment to the Division. No claims may be submitted by or through any clinic, group, corporation, or other association for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Medicaid program, except for those services or supplies provided prior to the suspension or termination effective date.

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 42 C.F.R. 440.230; 42 C.F.R. 440.260; 42 C.F.R. Part 431; 42 C.F.R. 431.54; 42 C.F.R. Part 455;*
Eff. May 1, 1984;
Amended Eff. December 1, 1995;
Readopted Eff. September 1, 2018.

10A NCAC 22F .0604 WITHHOLDING OF MEDICAID PAYMENTS

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 108C-5; 150B-21.6; 42 C.F.R. Part 431; 42 C.F.R. 455.23;*
Eff. May 1, 1984;
Amended Eff. December 1, 1995;
Repealed Eff. September 1, 2018.

10A NCAC 22F .0605 TERMINATION

History Note: *Authority G.S. 108A-25(b); 42 C.F.R. Part 431; 42 C.F.R. Part 455;*
Eff. May 1, 1984;
Repealed Eff. July 1, 2018.

10A NCAC 22F .0606 TECHNIQUE FOR PROJECTING MEDICAID OVERPAYMENTS

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-63; 42 C.F.R. Part 455, Subpart F;*
Eff. October 1, 1987;
Temporary Amendment Eff. November 8, 1996;
Amended Eff. August 1, 1998;
Repealed Eff. July 1, 2018.

SECTION .0700 – RECIPIENT FRAUD AND ABUSE

10A NCAC 22F .0701 DEFINITION OF FRAUD AND ABUSE

(a) For purposes of this Section the word "person" includes any natural person, association, consortium, corporation, body politic, partnership, or other group, entity or organization.

(b) Abuse. The type of abuse to which the Medicaid program is extremely vulnerable is recipient overutilization of medical and health care services for which he or she is eligible. A recipient may be regarded as overutilizing the program care and services if he or she has been furnished covered items or services at a frequency or amount not medically necessary, as determined in accordance with utilization guidelines established by the State, and the services were furnished at the request of the recipient.

History Note: *Authority G.S. 108A-25(b); 108A-64; 42 C.F.R. Part 431; 42 C.F.R. Part 455;*
42 C.F.R. Part 456;

Eff. May 1, 1984;
Amended Eff. May 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015.

10A NCAC 22F .0702 GENERAL

The Division will establish a statewide program for the prevention, detection, investigation, referral, prosecution, recoupment of overpayments, and reporting of fraud, abuse, and overutilization due to recipient aberrant practices. The program will be supervised by the Division and administered by the county departments of social services.

History Note: *Authority G.S. 108A-25(b); 108A-64; 42 C.F.R. Part 431; 42 C.F.R. Part 455; 42 C.F.R. Part 456;*
Eff. May 1, 1984;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015.

10A NCAC 22F .0703 WARNING NOTIFICATION

History Note: *Authority G.S. 108A-25(b); 108A-64; 42 C.F.R. Part 431; 42 C.F.R. Part 455; 42 C.F.R. Part 456;*
Eff. May 1, 1984;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22F .0704 RECIPIENT MANAGEMENT LOCK-IN SYSTEM

(a) The Division shall have methods and procedures for the control of recipient overutilization of Medicaid benefits. These methods and procedures shall include Lock-In of a recipient, shown to be an overutilizer, to specified providers of health care and services, as set out in 42 C.F.R. 440.230, 440.260, and 431.54(e), which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/.

(b) Prior to implementing Lock-In, the following steps shall be taken:

(1) Recipient's utilization pattern shall be documented as inappropriate;
(2) Recipient shall be notified that the State is imposing a Lock-In procedure;
(3) Recipient shall be offered the opportunity to select a provider;
(4) In the event the recipient fails to select a provider, a provider shall be selected for him or her by the Division; and
(5) Recipient shall receive an eligibility card indicating the selected providers.

(c) Recipient utilization patterns shall be reviewed to determine if changes have occurred. If the utilization pattern has been corrected, the Lock-In status shall end; if the utilization pattern remains inappropriate Lock-In status shall continue.

(d) The Division may Lock-In a recipient provided:

(1) the recipient is given notice and an opportunity for a hearing before imposing restriction, pursuant to G.S. 150B-23; and
(2) the Division assures that the recipient has reasonable access to Medicaid care and services of adequate quality, as set out in 42 C.F.R. 440.230, 440.260, and 431.54, which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/.

History Note: *Authority G.S. 108A-25(b); 108A-64; 108A-79; 42 C.F.R. 440.230; 42 C.F.R. 440.260; 42 C.F.R. Part 431; 42 C.F.R. 431.54; 42 C.F.R. Part 455; 42 C.F.R. Part 456;*
Eff. May 1, 1984;
Readopted Eff. July 1, 2018.

10A NCAC 22F .0705 OVERUTILIZATION SURVEILLANCE (SUR INDICATOR)

History Note: *Authority G.S. 108A-25(b); 108A-64; 42 C.F.R. Part 431; 42 C.F.R. Part 455; 42 C.F.R. Part 456;*

Eff. May 1, 1984;
Expired Eff. September 1, 2015 pursuant to G.S. 150B-21.3A.

10A NCAC 22F .0706 RECOUPMENT OF RECIPIENT OVERPAYMENTS

History Note: *Authority G.S. 108A-25(b); 108A-64; 42 C.F.R. Part 431; 42 C.F.R. Part 455; 42 C.F.R. Part 456;*
Eff. May 1, 1984;
Readopted Eff. July 1, 2018;
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