CHAPTER 75-02-02
MEDICAL SERVICES

Section	
75-02-02-01	Purpose [Repealed]
75-02-02-02	Authority and Objective
75-02-02-03	State Organization
75-02-02-03.1	Definitions [Repealed]
75-02-02-03.2	Definitions
75-02-02-04	Application and Decision [Repealed]
75-02-02-05	Furnishing Assistance [Repealed]
75-02-02-06	Coverage for Eligibility [Repealed]
75-02-02-07	Conditions of Eligibility [Repealed]
75-02-02-08	Amount, Duration, and Scope of Medical Assistance
75-02-02-09	Nursing Facility Level of Care
75-02-02-09.1	Cost Sharing
75-02-02-09.2	Limitations on Inpatient Rehabilitation
75-02-02-09.3	Limitations on Payment for Dental Services
75-02-02-09.4	General Limitations on Amount, Duration, and Scope
75-02-02-09.5	Limitations on Personal Care Services
75-02-02-10	Limitations on Inpatient Psychiatric Services
75-02-02-10.1	Limitations on Services in Psychiatric Residential Treatment Facilities
75-02-02-10.2	Limitations on Ambulatory Behavioral Health Care
75-02-02-11	Coordinated Services
75-02-02-12	Limitations on Emergency Room Services
75-02-02-13	Limitations on Out-of-State Care
75-02-02-13.1	Travel Expenses for Medical Purposes - Limitations
75-02-02-13.2	Travel Expenses for Medical Purposes – Institutionalized Individuals - Limitations
75-02-02-14	County Administration
75-02-02-15	Groups Covered [Repealed]
75-02-02-16	Basic Eligibility Factors [Repealed]
75-02-02-17	Blindness and Disability [Repealed]
75-02-02-18	Financial Eligibility [Repealed]
75-02-02-19	Income and Resource Considerations [Repealed]
75-02-02-20	Income Levels and Application [Repealed]
75-02-02-21	Property Resource Limits [Repealed]
75-02-02-22	Exempt Property Resources [Repealed]
75-02-02-23	Excluded Property Resources [Repealed]
75-02-02-24	Contractual Rights to Receive Money Payments [Repealed]
75-02-02-25	Disqualifying Transfers [Repealed]
75-02-02-26	Eligibility Under 1972 State Plan [Repealed]
75-02-02-27	Scope of Drug Benefits - Prior Authorization
75-02-02-28	Drug Use Review Board and Appeals
75-02-02-29	Primary Care Provider

SECTION 1. Subdivision l of subsection 1 of section 75-02-02-08 is amended as follows:

75-02-02-08. Amount, duration, and scope of medical assistance.

1. Within any limitations which may be established by rule, regulation, or statute and within the limits of legislative appropriations, eligible recipients may obtain the medically necessary medical and remedial care and services which are described in the approved medicaid state plan in effect at the time the service is rendered by providers. Services may include:

    l. Dental services. "Dental services" means any diagnostic, preventive, or corrective procedures administered by or under the supervision of a dentist in the practice of the dentist's profession and not excluded from coverage. Dental services include treatment of the teeth and associated structures of the oral cavity, and of disease, injury, or impairment which may affect the oral or general health of the individual. Dental services reimbursed under 42 C.F.R. 440.90 may only be reimbursed if provided through a public or private nonprofit entity that provides dental services.

History: Amended effective September 1, 1978; September 2, 1980; February 1, 1981; November 1, 1983; May 1, 1986; November 1, 1986; November 1, 1987; January 1, 1991; July 1, 1993; January 1, 1994; January 1, 1996; July 1, 1996; January 1, 1997; May 1, 2000; amendments partially voided by the Administrative Rules Committee effective June 5, 2000; November 8, 2002; September 1, 2003; July 1, 2006; January 1, 2010; July 1, 2012; October 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 USC 1396n(b)(1); 42 CFR 431.53; 42 CFR 431.110; 42 CFR 435.1009; 42 CFR Part 440; 42 CFR Part 441, subparts A, B, D

SECTION 2. Section 75-02-02-10.2 is amended as follows:

75-02-02-10.2. Limitations on ambulatory behavioral health care.

1. For purposes of this section:
    a. "Ambulatory behavioral health care" means ambulatory services provided to an individual with a significant impairment resulting from a psychiatric, emotional, behavioral, or addictive disorder which are provided by a multidisciplinary team of health care professionals and are designed to stabilize the health of the individual with the intent to avert inpatient hospitalization in place of inpatient ~~hospitilization~~ hospitalization or to reduce the length of a hospital stay. Ambulatory behavioral health care may be hospital-based or community–based.
    b. "~~Level A~~ American Society of Addiction Medicine II.5 ambulatory behavioral health care" means an intense level of ambulatory behavioral health care which provides treatment for an individual by

at least three licensed health care professionals under the supervision of a licensed physician for at least four hours and no more than eleven hours per day for at least three days per week.

c. "~~Level B~~ American Society of Addiction Medicine II.1 ambulatory behavioral health care" means an intermediate level of ambulatory behavioral health care that provides treatment for an individual by at least three licensed health care professionals under the supervision of a licensed physician for three hours per day for at least two days per week.

d. "~~Level C~~ American Society of Addiction Medicine I ambulatory behavioral health care" means a low level of ambulatory behavioral health care that provides chemical dependency treatment for an individual by at least one licensed health care professional under the supervision of a licensed physician for less than three hours per day and no more than three days per week.

2. No payment for ambulatory behavioral health care will be made unless the provider requests authorization from the department within three business days of providing such services and the department approves such request. A provider must submit a written request for authorization to the department on forms prescribed by the department.

3. Limitations.

a. Payment may not be made for ~~level A~~ American Society of Addiction Medicine II.5 ambulatory behavioral health care services exceeding ~~thirty~~ forty-five days per calendar year per individual.

b. Payment may not be made for ~~level B~~ American Society of Addiction Medicine II.1 ambulatory behavioral health care services exceeding ~~fifteen~~ thirty days per calendar year per individual.

c. Payment may not be made for ~~level C~~ American Society of Addiction Medicine I ambulatory behavioral health care services exceeding twenty days per calendar year per individual. The department may approve an additional ten days per calendar year per individual on a case-by-case basis.

History: Effective November 8, 2002; amended effective November 19, 2003; October 1, 2012; July 1, 2014.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 431.54

SECTION 3. Subdivision c of subsection 2 of section 75-02-02-13.1 is amended as follows:

75-02-02-13.1. Travel expenses for medical purposes - Limitations.

c. The cost of travel provided by a parent, spouse, or any other member of the recipient's medical assistance unit may be allowed as an expense of necessary medical or remedial care for recipient liability purposes. No parent, spouse, friend, household member, or

family member of the recipient may be paid as an enrolled provider for transportation for that recipient. An individual who ~~is court-appointed for~~ provides foster care, kinship, or guardianship may enroll as a transportation provider and is eligible for reimbursement to transport a medicaid-eligible child ~~in the individual's court-appointed custody~~ to and from medicaid-covered medical appointments.

History: Effective July 1, 1996; amended effective May 1, 2000; September 1, 2003; October 1, 2012; July 1, 2014.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

SECTION 4. Subsection 7 of section 75-02-02-29 is amended as follows:

75-02-02-29. Primary care provider.

7. A primary care provider may be changed during the ninety days after the recipient's initial enrollment with the primary care provider or the date the state sends the recipient notice of the enrollment, at redetermination of eligibility, once every six months during the open enrollment period, or with good cause. Good cause for changing a primary care provider less than six months after the previous selection of a primary care provider exists if:
   a. The recipient relocates;
   b. Significant changes in the recipient's health require the selection of a primary care provider with a different ~~speciality~~ specialty;
   c. The primary care provider relocates or is reassigned;
   d. The selected provider refuses to act as a primary care provider or refuses to continue to act as a primary care provider; or
   e. The department, or its agents, determines that a change of primary care provider is necessary.

History: Effective October 1, 2012; amended effective July 1, 2014.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-32; 42 USC 1396u-2