

**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75-02-02-01	Purpose [Repealed]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75-02-02-03.1	Definitions [Repealed]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75-02-02-04	Application and Decision [Repealed]
75-02-02-05	Furnishing Assistance [Repealed]
75-02-02-06	Coverage for Eligibility [Repealed]
75-02-02-07	Conditions of Eligibility [Repealed]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 for Individuals Under Age Twenty-One
75-02-02-10.1	Limitations on Inpatient Psychiatric Services
75-02-02-10.2	Limitations on Services for Treatment of Addiction
75-02-02-10.3	Limitations on Partial Hospitalization Psychiatric Services
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75-02-02-15	Groups Covered [Repealed]
75-02-02-16	Basic Eligibility Factors [Repealed]
75-02-02-17	Blindness and Disability [Repealed]
75-02-02-18	Financial Eligibility [Repealed]
75-02-02-19	Income and Resource Considerations [Repealed]
75-02-02-20	Income Levels and Application [Repealed]
75-02-02-21	Property Resource Limits [Repealed]
75-02-02-22	Exempt Property Resources [Repealed]
75-02-02-23	Excluded Property Resources [Repealed]
75-02-02-24	Contractual Rights to Receive Money Payments [Repealed]
75-02-02-25	Disqualifying Transfers [Repealed]
75-02-02-26	Eligibility Under 1972 State Plan [Repealed]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

75-02-02-01. Purpose.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-02. Authority and objective.

Under authority of North Dakota Century Code chapter 50-24.1, the department of human services is empowered to promulgate such rules and regulations as are necessary to qualify for federal funds under section 1901 specifically and title XIX generally of the Social Security Act. These regulations are subject to the medical assistance state plan and to applicable federal law and regulations.

General Authority: NDCC 50-06-05.1, 50-24.1-04

Law Implemented: NDCC 50-24.1-04; 42 USC 1396a

75-02-02-03. State organization.

1. **Single state agency.** The department of human services is the single state agency with authority to supervise the administration of the medical assistance plan and program.
2. **Statewide operation.**
 - a. The state plan will be in operation, through a system of local offices on a statewide basis, in accordance with equitable standards for assistance and administration that are mandatory throughout the state.
 - b. The state plan will be administered by the political subdivisions of the state and will be mandatory on such political subdivisions.
 - c. The department of human services, hereinafter referred to as the state agency, will assure that the plan is continuously in operation in all local offices or local agencies through:
 - (1) Methods for informing staff of state policies, standards, procedures, and instructions.
 - (2) Regular planned examination and evaluation of operations in local offices by regularly assigned state staff, including regular visits by such staff; and through reports, controls, or other necessary methods.

History: Amended effective May 1, 1986.

General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-06-05.1, 50-24.1-04; 42 CFR 431.10; 42 CFR 431.20

75-02-02-03.1. Definitions.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is repealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-03.2. Definitions.

For purposes of this chapter:

1. "Behavioral health service" means an evaluation, therapy, or testing service rendered by one of the following practitioners within their scope of practice: physician, licensed independent clinical social worker, psychologist, licensed addiction counselor, licensed associate professional counselor, licensed professional counselor, licensed professional clinical counselor, clinical nurse specialist, physician assistant, nurse practitioner, licensed social worker, licensed marriage and family therapist, or licensed certified social worker.
2. "Certification of need" means a regulatory review process that requires specific health care providers to obtain prior authorization for provision of services for Medicaid applicants or

eligible recipients under age twenty-one. Certification of need is a determination of the medical necessity of the proposed services as required for all applicants or recipients under the age of twenty-one prior to admission to a psychiatric hospital, an inpatient psychiatric program in a hospital, or a psychiatric facility, including a psychiatric residential treatment facility. The certification of need evaluates the individual's capacity to benefit from proposed services, the efficacy of proposed services, and consideration of the availability of less restrictive services to meet the individual's needs.

3. "County agency" means the county social service board.
4. "Department" means the North Dakota department of human services.
5. "Drug use review board" means the board established pursuant to North Dakota Century Code chapter 50-24.6.
6. "Exercise program" includes regimens to achieve various improvements in physical fitness and health.
7. "Home health agency" means a public or private agency or organization, or a subdivision of such an agency or organization, which is qualified to participate as a home health agency under title XVIII of the Social Security Act, or is determined currently to meet the requirements for participation.
8. "Indian health services or tribal health facility or clinic" means either a health services facility or clinic operated by the United States department of health and human services Indian health services division or a federally recognized tribal nation that has opted to contract with Indian health services to plan, conduct, and administer one or more individual programs, functions, services, or activities, resulting in tribal health facilities or clinics operated by tribes and tribal organizations under the Indian Self-Determination and Education Assistance Act [Pub. L. 93-638].
9. "Licensed practitioner" means an individual other than a physician who is licensed or otherwise authorized by the state to provide health care services within the practitioner's scope of practice.
10. "Medical emergency" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
11. "Medically necessary" includes only medical or remedial services or supplies required for treatment of illness, injury, diseased condition, or impairment; consistent with the recipient's diagnosis or symptoms; appropriate according to generally accepted standards of medical practice; not provided only as a convenience to the recipient or provider; not investigational, experimental, or unproven; clinically appropriate in terms of scope, duration, intensity, and site; and provided at the most appropriate level of service that is safe and effective.
12. "Provider" means an individual, entity, or facility furnishing medical or remedial services or supplies pursuant to a provider agreement with the department.
13. "Psychiatric residential treatment facility" is as defined in subsection 13 of section 75-03-17-01.
14. "Recipient" means an individual approved as eligible for medical assistance.

15. "Rehabilitative services" means any medical or remedial items or services prescribed for a recipient by the recipient's physician or other licensed practitioner of the healing arts, within the scope of the physician's or practitioner's practice as defined by state law, for the purpose of maximum reduction of physical or mental disability and restoration of the recipient to the recipient's best possible functional level.
16. "Remedial services" includes those services, including rehabilitative services, which produce the maximum reduction in physical or mental disability and restoration of a recipient to the recipient's best possible functional level.
17. "Weight loss program" includes programs designed for reduction in weight, but does not include weight loss surgery.
18. "Section 1931 group" includes individuals whose eligibility is based on the provisions of section 1931 of the Social Security Act [42 U.S.C. 1396u-1].

History: Effective May 1, 2000; amended effective August 29, 2000; November 1, 2001; September 1, 2003; October 1, 2012; April 1, 2016; January 1, 2017; April 1, 2018.

General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-24.1-01

75-02-02-04. Application and decision.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-05. Furnishing assistance.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-06. Coverage for eligibility.

Repealed effective May 1, 1986.

75-02-02-07. Conditions of eligibility.

Repealed effective May 1, 1986.

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:
 - a. (1) Inpatient hospital services. "Inpatient hospital services" means those items and services ordinarily furnished by the hospital for the care and treatment of inpatients provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases and which is licensed or formally approved as a hospital by an officially designated state standard-setting authority and is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation; and which has in effect a hospital utilization

review plan applicable to all patients who receive medical assistance under title XIX of the Act.

- (2) Inpatient prospective payment system hospitals that are reimbursed by a diagnostic-related group will follow Medicare guidelines for supplies and services included and excluded as outlined in 42 CFR 409.10.
- b. Outpatient hospital services. "Outpatient hospital services" means those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to an outpatient by an institution which is licensed or formally approved as a hospital by an officially designated state standard-setting authority and is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation and emergency hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available that is equipped to furnish such services, even though the hospital does not currently meet the conditions for participation under title XVIII of the Social Security Act.
 - c. Other laboratory and x-ray services. "Other laboratory and x-ray services" means professional and technical laboratory and radiological services ordered by a physician or other licensed practitioner of the healing arts within the scope of the physician's or practitioner's practice as defined by state law, and provided to a recipient by, or under the direction of, a physician or licensed practitioner, in an office or similar facility other than a hospital outpatient department or a clinic, and provided to a recipient by a laboratory that is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.
 - d. Nursing facility services. "Nursing facility services" does not include services in an institution for mental diseases and means those items and services furnished by a licensed and otherwise eligible nursing facility or swing-bed hospital maintained primarily for the care and treatment which are provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of the physician's or practitioner's practice as defined by state law for individuals who need or needed on a daily basis nursing care, provided directly or requiring the supervision of nursing personnel, or other rehabilitation services which, as a practical matter, may only be provided in a nursing facility on an inpatient basis.
 - e. Intermediate care facility for individuals with intellectual disabilities services. "Intermediate care" means those items and services which are provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of the physician's or practitioner's practice as defined by state law. "Intermediate care facility for individuals with intellectual disabilities" has the same meaning as provided in chapter 75-04-01.
 - f. Early and periodic screening, diagnosis, and treatment of individuals. "Early and periodic screening, diagnosis, and treatment" means the services provided to ensure that individuals under age twenty-one who are eligible under the plan receive appropriate, preventative, mental health developmental, and specialty services to correct or ameliorate medical conditions.
 - g. Physician's services. "Physician's services" whether furnished in the office, the recipient's home, a hospital, nursing facility, or elsewhere means those services provided, within the scope of practice of the physician's profession as defined by state law, by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy.

- h. Medical care and any other type of remedial care other than physician's services recognized under state law and furnished by licensed practitioners within the scope of their practice as defined by state law.
- i. Home health care services. "Home health care services", is in addition to the services of physicians, dentists, physical therapists, and other services and items available to recipients in their homes and described elsewhere in this section, means any of the following items and services when they are provided, based on physician order, medical necessity, and a written plan of care, to a recipient in the recipient's place of residence, excluding a residence that is a hospital or a skilled nursing facility:
 - (1) Intermittent or part-time skilled nursing services furnished by a home health agency;
 - (2) Intermittent or part-time nursing services of a registered nurse, or a licensed practical nurse, or which are provided under the direction of a physician and under the supervision of a registered nurse, when a home health agency is not available to provide nursing services;
 - (3) Medical supplies, equipment, and appliances ordered or prescribed by the physician as required in the care of the patient and suitable for use in the home; and
 - (4) Services of a home health aide provided to a patient in accordance with the plan of treatment outlined for the patient by the attending physician and in collaboration with the home health agency.
- j. Hospice care. "Hospice care" means the care described in 42 CFR 418 furnished to a terminally ill individual who has voluntarily elected to have hospice care. Hospice care may be provided to an individual while the individual is a resident of a nursing facility, but only the hospice care payment may be made. An individual's voluntary election must be made in accordance with procedures established by the department.
- k. Private duty nursing services. "Private duty nursing services" means nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or is routinely provided by the nursing staff of a medical facility. Services are provided by a registered nurse or a licensed practical nurse under the direction of and ordered by a physician.
- 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.
- m. Physical therapy. "Physical therapy" means those services prescribed by a physician or other licensed practitioner of the healing arts within the scope of that person's practice under state law and provided to a recipient by or under the supervision of a qualified physical therapist.
- n. Occupational therapy. "Occupational therapy" means those services prescribed by a physician or other licensed practitioner of the healing arts within the scope of that person's practice under state law and provided to a recipient and given by or under the supervision of a qualified occupational therapist.
- o. Services for individuals with speech, hearing, and language disorders. "Services for individuals with speech, hearing, and language disorders" means those diagnostic,

screening, preventive, or corrective services provided by or under the supervision of a speech pathologist or audiologist in the scope of practice of the speech pathologist's or audiologist's profession for which a recipient is referred by a physician or other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.

- p. Prescribed drugs. "Prescribed drugs" means any simple or compounded substance or mixture of substances prescribed as such or in other acceptable dosage forms for the cure, mitigation, or prevention of disease, or for health maintenance, by a physician or other licensed practitioner of the healing arts within the scope of the physician's or practitioner's professional practice as defined and limited by federal and state law.
- q. Durable medical equipment and supplies. "Durable medical equipment and supplies" means those medically necessary items that are primarily and customarily used to serve a medical purpose and are suitable for use in the home and used to treat disease, to promote healing, to restore bodily functioning to as near normal as possible, or to prevent further deterioration, debilitation, or injury which are provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of the physician's or practitioner's practice as defined by state law. Durable medical equipment includes prosthetic and orthotic devices, eyeglasses, and hearing aids. For purposes of this subdivision:
 - (1) "Eyeglasses" means lenses, including frames when necessary, and other aids to vision prescribed by a physician skilled in diseases of the eye, or by an optometrist, whichever the recipient may select, to aid or improve vision;
 - (2) "Hearing aid" means a specialized orthotic device individually prescribed and fitted to correct or ameliorate a hearing disorder; and
 - (3) "Prosthetic and orthotic devices" means replacement, corrective, or supportive devices prescribed for a recipient by a physician or other licensed practitioner of the healing arts within the scope of the physician's or practitioner's practice as defined by state law for the purpose of artificially replacing a missing portion of the body, or to prevent or correct physical deformity or malfunction, or to support a weak or deformed portion of the body.
- r. Other diagnostic, screening, preventive, and rehabilitative services.
 - (1) "Diagnostic services", other than those for which provision is made elsewhere in these definitions, includes any medical procedures or supplies recommended for a recipient by the recipient's physician or other licensed practitioner of the healing arts within the scope of the physician's or practitioner's practice as defined by state law, as necessary to enable the physician or practitioner to identify the existence, nature, or extent of illness, injury, or other health deviation in the recipient.
 - (2) "Preventive services" means those provided by a physician or other licensed practitioner of the healing arts, within the scope of the physician's or practitioner's practice as defined by state law, to prevent illness, disease, disability, and other health deviations or their progression, prolong life, and promote physical and mental health and efficiency.
 - (3) "Rehabilitative services", in addition to those for which provision is made elsewhere in these definitions, includes any medical or remedial items or services prescribed for a recipient by the recipient's physician or other licensed practitioner of the healing arts, within the scope of the physician's or practitioner's practice as defined

by state law, for the purpose of maximum reduction of physical or mental disability and restoration of the recipient to the recipient's best possible functional level.

- (4) "Screening services" consists of the use of standardized tests performed under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations, to identify suspects for more definitive studies, or identify individuals suspected of having certain diseases.
 - s. Inpatient psychiatric services for individuals under age twenty-one, as defined in 42 CFR 440.160, provided consistent with the requirements of 42 CFR part 441 and section 75-02-02-10.
 - t. Services provided to persons age sixty-five and older in an institution for mental diseases, as defined in 42 U.S.C. 1396d(i).
 - u. Personal care services. "Personal care services" means those services that assist an individual with activities of daily living and instrumental activities of daily living in order to maintain independence and self-reliance to the greatest degree possible.
 - v. Any other medical care and any other type of remedial care recognized under state law and specified by the secretary of the United States' department of health and human services, including:
 - (1) Nonemergency medical transportation, including expenses for transportation and other related travel expenses, necessary to securing medical examinations or treatment when determined by the department to be medically necessary.
 - (2) Family planning services, including drugs, supplies, and devices, when such services are under the medical direction of a physician or licensed practitioner of the healing arts within the scope of their practices as defined by state law. There must be freedom from coercion or pressure of mind and conscience and freedom of choice of method, so that individuals may choose in accordance with the dictates of their consciences.
 - (3) Whole blood, including items and services required in collection, storage, and administration, when it has been recommended by a physician or licensed practitioner and when it is not available to the recipient from other sources.
 - w. A community paramedic service. "Community paramedic service" means a Medicaid-covered service rendered by a community paramedic, advanced emergency medical technician, or emergency medical technician. The care must be provided under the supervision of a physician or advanced practice registered nurse.
2. The following limitations apply to medical and remedial care and services covered or provided under the medical assistance program:
- a. Coverage may not be extended and payment may not be made for an exercise program or a weight loss program prescribed for eligible recipients.
 - b. Coverage may not be extended and payment may not be made for alcoholic beverages prescribed for eligible recipients.
 - c. Coverage may not be extended and payment may not be made for orthodontia prescribed for eligible recipients, except for orthodontia necessary to correct serious functional problems.

- d. Coverage may not be extended and payment may not be made for any service provided to increase fertility or to evaluate or treat fertility.
- e. Coverage and payment for eye examinations and eyeglasses for eligible recipients are limited to, and payment will only be made for, examinations and eyeglass replacements necessitated because of visual impairment.
- f.
 - (1) Coverage may not be extended to and payment may not be made for any physician-administered drugs in an outpatient setting if the drug does not meet the requirements for a covered outpatient drug as outlined in section 1927 of the Social Security Act [42 U.S.C. 1396r-8].
 - (2) Payment for any physician-administered drugs in an outpatient setting will be the lesser of the provider's submitted charge, the Medicare allowed amount, or the pharmacy services allowed amount described in subdivision n.
- g. Coverage and payment for home health care services and private duty nursing services are limited to no more, on an average monthly basis, to the equivalent of one hundred seventy-five visits. The limit for private duty nursing is in combination with the limit for home health services.
 - (1) This limit may be exceeded in cases where it is determined there is a medical necessity for exceeding the limit and the department has approved a prior treatment authorization request.
 - (2) The prior authorization request must describe the medical necessity of the home health care services or private duty nursing services, and explain why less costly alternative treatment does not afford necessary medical care.
 - (3) At the time of initial ordering of home health services, a physician or other licensed practitioner shall document that a face-to-face encounter related to the primary reason the recipient requires home health services occurred no more than ninety days before or thirty days after the start of home health services.
- h. Coverage may not be extended and payment may not be made for transportation services except as provided in sections 75-02-02-13.1 and 75-02-02-13.2.
- i. Coverage may not be extended and payment may not be made for any abortion except when necessary to save the life of the mother or when the pregnancy is the result of an act of rape or incest.
- j. After consideration of North Dakota Century Code section 50-241-15, coverage for ambulance services must be in response to a medical emergency and may not be extended and payment may not be made for ambulance services that are not medically necessary, as determined by the department.
- k. Coverage for an emergency room must be made in response to a medical emergency and may not be extended and payment may not be made for emergency room services that are not medically necessary, as determined by the department under section 75-02-02-12.
- l. Coverage may not be extended and payment may not be made for medically necessary chiropractic services exceeding twelve treatments for spinal manipulation services and two radiologic examinations per year, per recipient, unless the provider requests and receives prior authorization from the department.
- m. Coverage and payment for personal care services:

- (1) May not be made unless prior authorization is granted, and the recipient meets the criteria established in subsection 1 of section 75-02-02-09.5; and
- (2) May be approved for:
 - (a) Up to one hundred twenty hours per month, or at a daily rate;
 - (b) Up to two hundred forty hours per month if the recipient meets the medical necessity criteria for nursing facility level of care described in section 75-02-02-09 or intermediate care facility for individuals with intellectual disabilities level of care; or
 - (c) Up to three hundred hours per month if the recipient is determined to be impaired in at least five of the activities of daily living of bathing, dressing, eating, incontinence, mobility, toileting, and transferring; meets the medical necessity criteria for nursing facility level of care described in section 75-02-02-09 or intermediate care facility for individuals with intellectual disabilities level of care; and none of the three hundred hours approved for personal care services are allocated to the tasks of laundry, shopping, or housekeeping.
- n. Coverage and payment for pharmacy services are limited to the coverage and methodology approved by the centers for Medicare and Medicaid services in the current North Dakota Medicaid state plan.
3.
 - a. Except as provided in subdivision b, remedial services are covered services.
 - b. Remedial services provided by residential facilities such as licensed basic care facilities, licensed foster care homes or facilities, and specialized facilities are not covered services, but expenses incurred in securing such services must be deducted from countable income in determining financial eligibility.
4.
 - a. The department may refuse payment for any covered service or procedure for which a prior treatment authorization request is required but not secured.
 - b. The department may consider making payment if the provider demonstrates good cause for the failure to secure the required prior treatment authorization request. Provider requests for good cause consideration must be received within twelve months of the date the services or procedures were furnished and any related claims must be filed within timely claims submission requirements.
 - c. The department may refuse payment for any covered service or procedure provided to an individual eligible for both Medicaid and third-party coverage if the third-party coverage denies payment because of the failure of the provider or recipient to comply with the requirements of the third-party coverage.
5. A provider who renders a covered service except for personal care, but fails to receive payment due to the requirements of subsection 4, may not bill the recipient. A provider who attempts to collect from the eligible recipient or the eligible recipient's responsible relatives any amounts which would have been paid by the department but for the requirements of subsection 4, has by so doing breached the terms of their Medicaid provider agreement.
6. Community paramedic services are limited to vaccinations, immunizations, and immunization administration.

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; July 1, 2014; April 1, 2016; January 1, 2017; April 1, 2018.

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

75-02-02-09. Nursing facility level of care.

1. "Nursing facility level of care" means, for purposes of medical assistance, services provided by a facility that meets the standards for nursing facility licensing established by the state department of health, and in addition, meets all requirements for nursing facilities imposed under federal law and regulations governing the medical assistance program.
2. Except as provided in subsection 3 or 4, an individual who applies for care in a nursing facility, or who resides in a nursing facility, may demonstrate that a nursing facility level of care is medically necessary only if any one of the criteria in this subsection is met.
 - a. The individual's nursing facility stay is, or is anticipated to be, temporary for receipt of Medicare part A benefits. A nursing facility stay may be based on this criterion for no more than fourteen days after termination of Medicare part A benefits.
 - b. The individual is in a comatose state.
 - c. The individual requires the use of a ventilator at least six hours per day, seven days a week.
 - d. The individual has respiratory problems that require regular treatment, observation, or monitoring that may only be provided by or under the direction of a registered nurse or, in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse, and is incapable of self-care.
 - e. The individual requires constant help sixty percent or more of the time with at least two of the activities of daily living of toileting, eating, transferring, and locomotion. For purposes of this subdivision, constant help is required if the individual requires a caregiver's continual presence or help without which the activity would not be completed.
 - f. The individual requires aspiration for maintenance of a clear airway.
 - g. The individual has dementia, physician-diagnosed or supported with corroborative evidence, for at least six months, and as a direct result of that dementia, the individual's condition has deteriorated to the point when a structured, professionally staffed environment is needed to monitor, evaluate, and accommodate the individual's changing needs.
3. If no criteria of subsection 2 is met, an individual who applies for care in a nursing facility or who resides in a nursing facility may demonstrate that a nursing facility level of care is medically necessary if any two of the criteria in this subsection are met.
 - a. The individual requires administration of prescribed:
 - (1) Injectable medication;
 - (2) Intravenous medication or solutions on a daily basis; or
 - (3) Routine oral medications, eye drops, or ointments on a daily basis.

- b. The individual has one or more unstable medical conditions requiring specific and individual services on a regular and continuing basis that can only be provided by or under the direction of a registered nurse or, in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse.
 - c. The individual is determined to have restorative potential and can benefit from restorative nursing or therapy treatments, such as gait training or bowel and bladder training, which are provided at least five days per week.
 - d. The individual requires administration of feedings by nasogastric tube, gastrostomy, jejunostomy, or parenteral route.
 - e. The individual requires care of decubitus ulcers, stasis ulcers, or other widespread skin disorders.
 - f. The individual requires constant help sixty percent or more of the time with any one of the activities of daily living of toileting, eating, transferring, or locomotion. For purposes of this subdivision, constant help is required if the individual requires a caregiver's continual presence or help without which the activity would not be completed.
4. If no criteria of subsection 2 or 3 is met, an individual who applies to or resides in a nursing facility designated as a facility for nongeriatric individuals with physical disabilities may demonstrate that a nursing facility level of care is medically necessary if the individual is determined to have restorative potential.
 5. If no criteria of subsection 2, 3, or 4 is met, an individual who applies for care in a nursing facility may demonstrate that a nursing level of care is medically necessary if:
 - a. The individual has an acquired brain injury, including anoxia, cerebral vascular accident, brain tumor, infection, or traumatic brain injury; and
 - b. As a result of the brain injury, the individual requires direct supervision at least eight hours a day, seven days a week.
 6.
 - a. Payment, by the department of human services, for care furnished in a nursing facility to individuals who were applicants for or recipients of medical assistance benefits prior to admission to the nursing facility may be made only for periods after a nursing facility level of care determination is made. If a nursing facility admits an individual who has applied for or is receiving medical assistance benefits before a nursing facility level of care determination is made, the nursing facility may not solicit or receive payment, from any source, for services furnished before the level of care determination is made.
 - b. Payment, by the department of human services, for care furnished in a nursing facility to individuals who become applicants for or recipients of medical assistance benefits after admission to the nursing facility may be made only after a nursing facility level of care determination is made.
 - c. Payment, by the department of human services, for care furnished in a nursing facility to individuals who are eligible for Medicare benefits related to that care, and who are also eligible for medical assistance, may be made only after a nursing facility level of care determination is made.
 7. A nursing facility shall ensure that appropriate medical, social, and psychological services are provided to each resident of the facility who is dependent in whole or in part on the medical assistance program under title XIX of the Social Security Act. The appropriateness of such services must be based on the need of each resident to attain or maintain the resident's

highest practicable physical, mental, and psychosocial well-being, and must consider, among other factors, age.

History: Amended effective September 1, 1979; July 1, 1993; November 1, 2001; October 1, 2012.

General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-24.1-04; 42 CFR Part 442

75-02-02-09.1. Cost sharing.

1. Copayments provided for in this section may be imposed unless:
 - a. The recipient receiving the service:
 - (1) Is in a nursing facility, intermediate care facility for individuals with intellectual disabilities, or any medical institution and is required to spend all income except for the recipient's personal needs allowance for the recipient's cost of care;
 - (2) Receives swing-bed services in a hospital;
 - (3) Has not reached the age of twenty-one years;
 - (4) Is pregnant;
 - (5) Is an Indian who is eligible to receive, is currently receiving, or who has ever received an item or service furnished by Indian health service providers or through referral under contract health services;
 - (6) Is terminally ill and is receiving hospice care;
 - (7) Is receiving medical assistance because of the state's election to extend coverage to eligible individuals receiving treatment for breast or cervical cancer; and
 - (8) Is an inmate, otherwise eligible for medical assistance, and is receiving qualifying inpatient services.
 - b. The service is:
 - (1) Emergency room services; or
 - (2) Family planning services.
2. Copayments are:
 - a. Seventy-five dollars for each inpatient hospital admission, including admissions to distinct part psychiatric and rehabilitation units of hospitals and excluding long-term hospitals;
 - b. Two dollars for each office or consultation visit;
 - c. Three dollars for each office visit to a rural health clinic or federally qualified health center;
 - d. One dollar for each chiropractic manipulation of the spine;
 - e. Two dollars for each dental visit that includes an oral examination;
 - f. Three dollars for each brand name prescription filled;
 - g. Two dollars for each optometric visit that includes a vision examination;

- h. Three dollars for each podiatric office visit;
- i. Two dollars for each occupational therapy visit;
- j. Two dollars for each physical therapy visit;
- k. One dollar for each speech therapy visit;
- l. Three dollars for each hearing aid dispensing service;
- m. Two dollars for each audiology testing visit;
- n. Two dollars for each behavioral health service visit; and
- o. Two dollars for each licensed independent clinical social worker visit.

History: Effective January 1, 1997; amended effective November 8, 2002; September 1, 2003; July 1, 2006; July 1, 2012; October 1, 2012; April 1, 2016; January 1, 2017; April 1, 2018.

General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-24.1-04

75-02-02-09.2. Limitations on inpatient rehabilitation.

No payment will be made for inpatient rehabilitation services provided to a recipient age twenty-one or older, in a distinct part unit of a hospital, except for the first thirty days of each admission.

History: Effective January 1, 1997.

General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-24.1-04

75-02-02-09.3. Limitations on payment for dental services.

1. No payment will be made for single crowns on posterior teeth for individuals twenty-one years of age and older except for stainless steel crowns. Payment for other crowns may be allowed by the department for the anterior portion of the mouth for adults if the crown is necessary and has been previously approved by the department.
2. No payment will be made for single crowns on posterior teeth for individuals under age twenty-one except for stainless steel crowns. Payment may be made if a dental condition exists that makes stainless steel crowns impracticable and the provider has secured the prior approval of the department.
3. Payment will be made for partial dentures for upper and lower temporary partial stayplate dentures. Payment may be made for other types of partial dentures designed to replace teeth in the anterior portion of the mouth if the provider secures prior approval from the department. Replacement of dentures is limited to every five years unless a medical condition of a recipient, verified by a dental consultant, renders the present dentures unusable. This limitation does not apply to individuals eligible for the early and periodic screening, diagnosis, and treatment program.

History: Effective September 1, 2003; amended effective October 1, 2012; April 1, 2016; April 1, 2018.

General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-24.1-04

75-02-02-09.4. General limitations on amount, duration, and scope.

1. Covered medical or remedial services or supplies are medically necessary when determined so by the medical provider unless the department has:

- a. Denied a prior treatment authorization request to provide the service;
 - b. Imposed a limit that has been exceeded;
 - c. Imposed a condition that has not been met;
 - d. Upon review under North Dakota Century Code chapter 50-24.1, determined that the service or supplies are not medically necessary.
2. Limitations on payment for occupational therapy, physical therapy, and speech therapy.
 - a. No payment will be made for an occupational therapy evaluation except one per calendar year or for occupational therapy provided to individuals twenty-one years of age and older except for twenty visits per individual per calendar year unless the provider requests and receives prior authorization from the department. This limit applies in combination with services delivered by independent occupational therapists and in outpatient hospital settings.
 - b. No payment will be made for a physical therapy evaluation except one per calendar year or for physical therapy provided to individuals twenty-one years of age and older except for fifteen visits per individual per calendar year unless the provider requests and receives prior authorization from the department. This limit applies in combination with services delivered by independent physical therapists and in outpatient hospital settings.
 - c. No payment will be made for a speech therapy evaluation except one per calendar year or for speech therapy provided to individuals twenty-one years of age and older except for thirty visits per individual per calendar year unless the provider requests and receives prior authorization from the department. This limit applies in combination with services delivered by independent speech therapists and in outpatient hospital settings.
 3. Limitation on payment for eye services.
 - a. No payment will be made for eyeglasses for individuals twenty-one years of age and older except for one pair of eyeglasses no more often than once every two years. No payment will be made for the repair or replacement of eyeglasses during the two-year period unless the provider has secured the prior approval of the department and the department has found that the repair or replacement is medically necessary.
 - b. No payment will be made for refractive examinations for individuals twenty-one years of age and older except for one refractive examination no more often than every two years after an initial examination paid by the department unless the provider has secured the prior approval of the department.
 4. Limitation on chiropractic services.
 - a. No payment will be made for spinal manipulation treatment services except for twelve spinal manipulation treatment services per individual per calendar year unless the provider requests and receives the prior approval of the department.
 - b. No payment will be made for radiologic examinations performed by a chiropractor except for two radiologic examinations per individual per year unless the provider requests and receives the prior approval of the department.
 5. Limitation on behavioral health services.
 - a. No payment will be made for psychological therapy visits except for forty visits per individual per calendar year.

- b. No payment will be made for psychological evaluations except for one per calendar year.
- c. No payment will be made for psychological testing except for ten units per calendar year.

Limitations in this subsection apply for services rendered by practitioners described in subsection 1 of section 75-02-02-03.2 with the exception of physicians, clinical nurse specialists, physician assistants, or nurse practitioners. Services in excess of the limits are not eligible for Medicaid payment unless the additional services are medically necessary and the provider requests and receives the prior approval of the department.

History: Effective September 1, 2003; amended effective July 1, 2006; July 1, 2009; October 1, 2012; April 1, 2016; January 1, 2017; April 1, 2018.

General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-24.1-04

75-02-02-09.5. Limitations on personal care services.

1. No payment for personal care services may be made unless an assessment of the recipient is made by the department or the department's designee and the recipient is determined to be impaired in at least one of the activities of daily living of bathing, dressing, eating, incontinence, mobility, toileting, and transferring or in at least three of the instrumental activities of daily living of medication assistance, laundry, housekeeping, and meal preparation.
2. No payment may be made for personal care services unless prior authorization has been granted by the department.
3. Payment for personal care services may only be made to an enrolled qualified service provider who meets the standards described in chapter 75-03-23 or to a basic care assistance provider that qualifies for a rate under chapter 75-02-07.1.
4. No payment may be made for personal care services provided in excess of the services, hours, or time frame authorized by the department in the recipient's approved service plan.
5. Personal care services may not include skilled health care services performed by persons with professional training.
6. An inpatient or resident of a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, a psychiatric residential treatment facility, or an institution for mental diseases may not receive personal care services.
7. Personal care services may not include home-delivered meals, services performed primarily as housekeeping tasks, transportation, social activities, or services or tasks not directly related to the needs of the recipient such as doing laundry for family members, cleaning of areas not occupied by the recipient, shopping for items not used by the recipient, or for tasks when they are completed for the benefit of both the client and the provider.
8. Payment for the tasks of laundry, shopping, housekeeping, meal preparation, money management, and communication cannot be made to a provider who lives with the client and is a relative listed under the definition of family home care under subsection 4 of North Dakota Century Code section 50-06.2-02 or is a former spouse.
9. Meal preparation is limited to the maximum units set by the department. Laundry, shopping, and housekeeping tasks when provided as personal care services must be incidental to the provision of other personal care tasks and cannot exceed thirty percent of the total time authorized for the provision of all personal care tasks. Personal care service tasks of laundry,

shopping, and housekeeping are limited to the maximum units set by the department, and the cap cannot be exceeded under other home and community-based services funding sources.

10. No payment may be made for personal care services provided to a recipient by the recipient's spouse, parent of a minor child, or legal guardian.
11. No payment may be made for care needs of a recipient which are outside the scope of personal care services.
12. Authorized personal care services may only be approved for:
 - a. Up to one hundred twenty hours per month;
 - b. Up to two hundred forty hours per month, if the recipient meets the medical necessity criteria for nursing facility level of care described in section 75-02-02-09 or intermediate care facility for individuals with intellectual disabilities level of care; or
 - c. Up to three hundred hours per month if the recipient is determined to be impaired in at least five of the activities of daily living of bathing, dressing, eating, incontinence, mobility, toileting, and transferring; meets the medical necessity criteria for nursing facility level of care described in section 75-02-02-09 or intermediate care facility for individuals with intellectual disabilities level of care; and none of the three hundred hours approved for personal care services are allocated to the tasks of laundry, shopping, or housekeeping.
13. Personal care services may only be provided when the needs of the recipient exceed the abilities of the recipient's spouse or parent of a minor child to provide those services. Personal care services may not be substituted when a spouse or parent of a minor child refuses or chooses not to perform the service for a recipient. Personal care services may be provided during periods when a spouse or parent of a minor child is gainfully employed if the services cannot be delayed until the spouse or parent is able to perform them.
14. Personal care services may not be provided for tasks that are otherwise age appropriate or generally needed by an individual within the normal stages of development.
15. The authorization for personal care services may be terminated if the services are not used within sixty days, or if services lapse for at least sixty days, after the issuance of the authorization to provide personal care services.
16. The department may deny or terminate personal care services when service to the client presents an immediate threat to the health or safety of the client, the provider of services, or others, or when services that are available are not adequate to prevent a threat to the health or safety of the client, the provider of services, or others.
17. Decisions regarding personal care services for an incapacitated client are health care decisions that may be made pursuant to North Dakota Century Code section 23-12-13.
18. The applicant or guardian of the applicant shall provide information sufficient to establish eligibility for benefits, including a social security number, proof of age, identity, residence, blindness, disability, functional limitation, financial eligibility, and such other information as may be required by this chapter for each month for which benefits are sought.
19. Payment for personal care services may not be made unless the client has been determined eligible to receive Medicaid benefits.
20. A daily rate for personal care may be authorized, at the discretion of the department, when determined necessary to maintain a recipient in the least restrictive setting.

History: Effective July 1, 2006; amended effective January 1, 2010; July 1, 2012; October 1, 2012; April 1, 2016; April 1, 2018.

General Authority: NDCC 50-24.1-18

Law Implemented: NDCC 50-24.1-18; 42 CFR Part 440.167

75-02-02-10. Limitations on inpatient psychiatric services for individuals under age twenty-one.

1. Inpatient psychiatric services for individuals under age twenty-one must be provided:
 - a. Under the direction of a physician;
 - b. By a psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the joint commission on accreditation of health care organizations, or by a psychiatric facility that is not a hospital and which is accredited by the joint commission on accreditation of health care organizations, the commission on accreditation of rehabilitation facilities, the council on accreditation of services for families and children, or by any other accrediting organization with comparable standards; and
 - c. Before the recipient reaches age twenty-one, or, if the individual was under age twenty-one at the time of admission, before the earlier of:
 - (1) The date the recipient no longer requires inpatient psychiatric services; or
 - (2) The date the recipient reaches age twenty-two.
2. A psychiatric facility or program providing inpatient psychiatric services to individuals under age twenty-one shall:
 - a. Except as provided in subdivision c, obtain a certification of need from an independent review team qualified under subsection 3 prior to admitting a recipient;
 - b. Obtain a certification of need from an independent review team qualified under subsection 3 for an individual who applies for medical assistance while in the facility or program covering any period for which claims are made; or
 - c. Obtain a certification of need from an independent review team qualified under subsection 3 for an emergency admission of an individual, within fourteen days after the admission, covering any period prior to the certification for which claims are made.
3. a. An independent review team must:
 - (1) Be composed of individuals who have no business or personal relationship with the inpatient psychiatric facility or program requesting a certification of need;
 - (2) Include a physician;
 - (3) Have competence in diagnosis and treatment of mental illness; and
 - (4) Have knowledge of the recipient's situation for which the certification of need is requested.
- b. Before issuing a certification of need, an independent review team must use professional judgment and standards approved by the department and consistent with the requirements of 42 CFR part 441, subpart D, to demonstrate:
 - (1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;

- (2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
 - (3) The requested services can reasonably be expected to improve the recipient's condition or prevent further regression so services may no longer be needed.
4. Payment may not be made for services provided to a recipient under age twenty-one in a psychiatric residential treatment facility without a certification of need.
 5. Prior to the dates of services of January 1, 2019, payment may not be made for any other medical services not provided by a psychiatric residential treatment facility if the facility is an institution for mental diseases.

History: Amended effective January 1, 1997; November 1, 2001; November 8, 2002; July 1, 2006; October 1, 2012; April 1, 2018.

General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-24.1-04; 42 CFR Part 441, subpart D

75-02-02-10.1. Limitations on inpatient psychiatric services.

No payment may be made for inpatient psychiatric services provided to a recipient, other than those described in section 75-02-02-10, in a distinct part unit of a hospital except for the first twenty-one days of each admission and not to exceed forty-five days per calendar year per recipient.

History: Effective November 1, 2001; amended effective October 1, 2012; April 1, 2018.

General Authority: NDCC 50-24.1-04; 42 CFR456.1; 42 CFR 456.3

Law Implemented: NDCC 50-24.1-04; 42 CFR Part 441, subpart D

75-02-02-10.2. Limitations on services for treatment of addiction.

1. For purposes of this section:
 - a. "Services for treatment of addiction" means ambulatory services provided to an individual with an impairment resulting from an addictive disorder which are provided by a multidisciplinary team of health care professionals and are designed to stabilize the health of the individual. Services for treatment of addiction may be hospital-based or nonhospital-based.
 - b. "American Society of Addiction Medicine II.5" means an intense level of services for treatment of addiction as prescribed in article 75-09.1.
 - c. "American Society of Addiction Medicine II.1" means an intermediate level of services for treatment of addiction as prescribed in article 75-09.1.
 - d. "American Society of Addiction Medicine I" means a low level of ambulatory behavioral health care that provides chemical dependency treatment for services for treatment of addiction as prescribed in article 75-09.1.
2. No payment for services for treatment of addiction will be made unless the provider requests authorization from the department within five 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 American Society of Addiction Medicine II.5 services exceeding forty-five days per calendar year per recipient.
 - b. Payment may not be made for American Society of Addiction Medicine II.1 services exceeding thirty days per calendar year per recipient.
 - c. Payment may not be made for American Society of Addiction Medicine I services exceeding twenty days per calendar year per recipient.
 - d. The department may approve additional days per calendar year per recipient on a case-by-case basis.
4. Licensed addiction counselors, operating within their scope of practice, performing American Society of Addiction Medicine I, and practicing within a recognized Indian reservation in North Dakota are not required to also have licensure prescribed in article 75-09.1, for Medicaid American Society of Addiction Medicine I billed services provided within a recognized Indian reservation in North Dakota.

History: Effective November 8, 2002; amended effective November 19, 2003; October 1, 2012; July 1, 2014; April 1, 2018.

General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-24.1-04; 42 CFR Part 431.54

75-02-02-10.3. Limitations on partial hospitalization psychiatric services.

1. For purposes of this section:
 - a. "Partial hospitalization psychiatric services" means services provided to an individual with an impairment resulting from a psychiatric, emotional, or behavior 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 or to reduce the length of a hospital stay. Partial hospitalization psychiatric services must be hospital based.
 - b. "Level A" means an intense level of partial hospitalization psychiatric services which provide 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" means an intermediate level of partial hospitalization psychiatric services which provide 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.
2. No payment for partial hospitalization psychiatric services may be made unless the provider requests authorization from the department within five business days of providing such services and the department approves such request. A provider shall 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 services exceeding forty-five days per calendar year per recipient.
 - b. Payment may not be made for level B services exceeding thirty days per calendar year per recipient.

- c. The department may approve additional days per calendar year per recipient on a case-by-case basis.

History: Effective April 1, 2018.

General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-24.1-04; 42 CFR Part 431.54

75-02-02-11. Coordinated services.

1. For purposes of this section:
 - a. "Coordinated services" means the process used to limit a recipient's medical care and treatment to a single physician or other provider to prevent the continued misutilization of services.
 - b. "Coordinated services provider" means a physician, nurse practitioner, physician assistant, or Indian health services or tribal health facility or clinic selected by the coordinated services recipient to provide care and treatment to the recipient. The selected coordinated services provider is subject to approval by the department.
 - c. "Misutilization" means the incorrect, improper, or excessive utilization of medical services which may increase the possibility of adverse effects to a recipient's health or may result in a decrease in the overall quality of care.
2. Coordinated services may be required by the department of a past, current, or future recipient who has misutilized services, including:
 - a. Securing excessive services from more than one provider when there is little or no evidence of a medical need for those services;
 - b. Drug acquisition in excess of medical need resulting from securing prescriptions or drugs from more than one provider;
 - c. Excessive utilization of emergency services when no medical emergency is present; or
 - d. Causing services to be misutilized due to fraud, deception, or direct action, without regard to payer source.
3. The determination to require coordinated services of a recipient is made by the department upon recommendation of medical professionals who have reviewed and identified the services the recipient appears to be misutilizing.
4. The following factors must be considered in determining if coordinated services is to be required:
 - a. The seriousness of the misutilization;
 - b. The historical utilization of the recipient; and
 - c. The availability of a coordinated services physician or provider.
5. If a coordinated services recipient does not select a coordinated services provider within thirty days after qualifying for the program, the department will limit the recipient to only medically necessary medical and pharmacy services. If a coordinated services recipient selects a coordinated services provider after the initial thirty days, the selection will be reviewed by the department to determine if the selected provider is appropriate and to ensure the provider accepts the assignment. A coordinated services recipient may have a coordinated services provider in more than one specialty, such as medical, dental, or pharmacy.

6. Upon a determination to require coordinated services:
 - a. The department shall provide the recipient with written notice of:
 - (1) The decision to require coordinated services;
 - (2) The recipient's right to choose a coordinated services provider, subject to approval by the department and acceptance by the provider;
 - (3) The recipient's responsibility to pay for medical care or services rendered by any provider other than the coordinated services provider; and
 - (4) The recipient's right to appeal the requirement of enrollment into the coordinated services program.
 - b. The appropriate county agency shall:
 - (1) Obtain the recipient's selection of a coordinated services provider; and
 - (2) Document that selection in the case record.
7. Coordinated services may be required of an individual recipient and may not be imposed on an entire medical assistance case. If more than one recipient within a case is misutilizing medical care, each individual recipient must be treated separately.
8. Coordinated services may be required without regard to breaks in eligibility until the department determines coordinated services is discontinued.
9. No medical assistance payment may be made for misutilized medical care or services furnished to the coordinated services recipient by any provider other than the recipient's coordinated services physician or provider, except for:
 - a. Medical care rendered in a medical emergency; or
 - b. Medical care rendered by a provider upon referral by the coordinated services physician or provider and approved by the department.
10. A recipient may appeal the decision to require coordinated services in the manner provided by chapter 75-01-03.

History: Effective May 1, 1981; amended effective May 1, 2000; July 1, 2006; October 1, 2012; April 1, 2016; April 1, 2018.

General Authority: NDCC 50-24.1-02

Law Implemented: NDCC 50-24.1-01; 42 CFR Part 455

75-02-02-12. Limitations on emergency room services.

1. For purposes of this section, "screening" means the initial evaluation of an individual, intended to determine suitability for a particular medical treatment modality.
2. The provider of emergency services shall assure that a recipient is referred to the appropriate health delivery setting, including the recipient's primary care provider, when emergency room services are not judged to be appropriate.
3. Payment for emergency room services.
 - a. Claims for payment, and documentation in support of those claims, must be submitted on forms prescribed by the department. The claim must contain sufficient documentation to

indicate that a medical emergency required emergency room diagnostic services and treatment.

- b. Except as provided in subsection 4, providers must be paid for any medically necessary services.
 - c. Except as provided in subsection 4, providers must be paid for screening or examination services rendered.
 - d. Providers must be paid for services rendered to recipients who reside outside of the provider's regular service area and who do not normally utilize the provider's services.
4. If the emergency room service claim does not demonstrate the existence of a medical emergency, payment must be denied (except for screening services) unless the services are shown to be medically necessary by a redetermination. The provider, upon receipt of notice of denial, may, in writing, make a redetermination request to the department. A redetermination must include a statement refuting the stated basis for the payment denial and affirmatively demonstrating a medical emergency.

History: Effective February 1, 1982; amended effective May 1, 2000; October 1, 2012; April 1, 2016; April 1, 2018.

General Authority: NDCC 50-24.1-02

Law Implemented: NDCC 50-24.1-01; 42 CFR Part 455

75-02-02-13. Limitations on out-of-state care.

1. For purposes of this section:
 - a. "Out-of-state care" means care or services furnished by any individual, entity, or facility, pursuant to a provider agreement with the department, at a site located more than fifty statute miles [80.45 kilometers] from the nearest North Dakota border.
 - b. "Out-of-state provider" means a provider of care or services that is located more than fifty statute miles [80.45 kilometers] outside of North Dakota. An out-of-state provider may be an individual or a facility but may not be located outside of the United States.
 - c. "Primary care provider" means the enrolled medical provider who has assumed responsibility for the advice and care of the recipient.
 - d. "Specialist" means a physician board certified in the required medical specialty who regularly practices within North Dakota or at a site within fifty statute miles [80.45 kilometers] from the nearest North Dakota border.
2. Except as provided in subsection 3, no payment for out-of-state care, including related travel expenses, will be made unless:
 - a. The recipient was first seen by that recipient's primary care provider, unless the recipient is not required to have a primary care provider;
 - b. The primary care provider determines, unless the recipient is not required to have a primary care provider, that it is advisable to refer the recipient for care or services which the primary care provider is unable to render and a referral is made to an in-state, board-certified physician specialist, if available;
 - c. Recipient is evaluated by a board-certified physician specialist;
 - d. The physician specialist concludes that the recipient should be referred to an appropriate out-of-state provider because necessary care or services are unavailable in the state;

- e. The primary care provider or in-state, board-certified physician specialist submits, to the department, a written request that includes medical and other pertinent information, including the report of the specialist that documents the specialist's conclusion that the out-of-state referral is medically necessary;
 - f. The department determines that the medically necessary care and services are unavailable in the state and approves the referral on that basis; and
 - g. The claim for payment is otherwise allowable and verifies that the department approved the referral for out-of-state care.
3. a. A referral for emergency care, including related travel expenses, to an out-of-state provider can be made by the in-state primary care provider. A determination that the emergency requires out-of-state care may be made at the primary care provider's discretion, but is subject to review by the department. Claims for payment for such emergency services must identify the referring primary care provider and document the emergency.
- b. Claims for payment for care for a medical emergency or surgical emergency, as those terms are defined in section 75-02-02-12, which occurs when the affected recipient is traveling outside of North Dakota, will be paid unless payment is denied pursuant to limitations contained in section 75-02-02-12.
- c. Claims for payment for any covered service rendered to a recipient who is a resident of North Dakota for medical assistance purposes, but whose current place of abode is outside of North Dakota, will not be governed by this section.
- d. Claims for payment for any covered service rendered to a recipient during a verified retroactive eligibility period will not be governed by this section.
- e. If a recipient is referred for out-of-state care without first securing approval under subsection 2, and the care is not otherwise allowable under this subsection, the department may approve payment upon receipt of a written request, from the primary care provider or specialist, that:
- (1) Demonstrates good cause for not first securing approval under subsection 2;
 - (2) Clearly establishes that the care and services were unavailable in the state; and
 - (3) Documents that the care and services were medically necessary.
4. An out-of-state provider who does not maintain a physical, in-state location or a location within fifty statute miles [80.45 kilometers] of North Dakota will not be enrolled as a Medicaid provider unless the department determines the provider's enrollment is necessary to ensure access to covered services.

History: Effective November 1, 1983; amended effective October 1, 1995; October 1, 2012; April 1, 2018.

General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-24.1-02

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

1. For purposes of this section:

- a. "Family member" means spouse, sibling, parent, stepparent, child, stepchild, grandparent, stepgrandparent, grandchild, stepgrandchild, aunt, uncle, niece, or nephew, whether by half or whole blood, and whether by birth, marriage, or adoption; and
 - b. "Travel expenses" means fares, mileage, meals, lodging, and driver and attendant care.
2. General requirements.
- a. A transportation service provider shall be enrolled as a provider in the medical assistance program and may be an individual, a taxi, a bus, a food service provider, a lodging provider, an airline service provider, a travel agency, or another commercial form of transportation.
 - b. The county agency may determine and authorize the most efficient, economical, and appropriate means of travel to meet the medical needs of the recipient.
 - 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 provides foster care, kinship, or guardianship may enroll as a transportation provider and is eligible for reimbursement to transport a Medicaid-eligible child to and from Medicaid-eligible medical appointments in situations in which the Medicaid-eligible child's medical needs exceed ordinary, typical, and routine levels. A guardian of a vulnerable adult may enroll as a transportation provider and is eligible for reimbursement to transport a Medicaid-eligible adult, for whom the guardian has been court-ordered to provide guardianship services, to and from Medicaid-covered medical appointments.
 - d. Emergency transport by ambulance is a covered service when provided in response to a medical emergency.
 - e. Nonemergency transportation by ambulance is a covered service only when medically necessary and ordered by the attending licensed provider.
 - f. A recipient may choose to obtain medical services outside the recipient's community. If similar medical services are available within the community and the recipient chooses to seek medical services elsewhere, travel expenses are not covered services and are the responsibility of the recipient.
 - g. If a provider refers a recipient to a facility or provider that is not located at the closest medical center, travel expenses are not covered services and are the responsibility of the recipient, unless special circumstances apply and prior authorization is secured.
3. Out-of-state travel expenses. Travel expenses for nonemergency out-of-state medical services, including follow-up visits, may be authorized if the out-of-state medical services are first approved by the department under section 75-02-02-13 or if prior approval is not required under that section.
4. Limitations.
- a. Private or noncommercial vehicle mileage compensation is limited to the amount on the department fee schedule. This limit applies even if more than one recipient is transported at the same time. Mileage is determined by map miles from the residence or community of the recipient to the medical facility. When necessary to ensure volunteer drivers continue to provide transportation services to a recipient, the county agency may request authorization from the department to make payment for additional mileage.

Transportation services may be billed to medical assistance only upon completion of the service. Transportation services may be allowed if the recipient or a household member does not have a vehicle that is in operable condition or if the health of the recipient or household member does not permit safe operation of the vehicle. If free or low-cost transportation services are available, including transportation that could be provided by a friend, family member, or household member, the department will not pay transportation costs.

- b. Meals compensation is allowed only when medical services or travel arrangements require a recipient to stay overnight. Compensation is limited to the amount on the department fee schedule. The entity providing meals must be an enrolled Medicaid provider and must submit the proper requests for payment.
- c. Lodging expense is allowed only when medical services or travel arrangements require a recipient to stay overnight. Lodging compensation is limited to the amount on the department fee schedule. Lodging providers must be enrolled in Medicaid and shall submit the proper requests for payment.
- d. Travel expenses may not be authorized for both a driver and an attendant unless the referring licensed practitioner determines that one individual cannot function both as driver and attendant. Travel expenses may not be allowed for a noncommercial driver or an attendant while the recipient is a patient in a medical facility unless it is more economical for the driver or attendant to remain in the service area, as determined by the department.
- e. Travel expenses may be authorized for one parent to travel with a child who is under eighteen years of age. No additional travel expenses may be authorized for another driver, attendant, or parent unless the referring licensed practitioner determines that person's presence is necessary for the physical, psychological, or medical needs of the child.
- f. Compensation for attendant services, provided by an attendant who is not a family member, may be allowed at a rate determined by the department if the department determines attendant services are medically necessary. Attendant services must be approved by the county agency.

History: Effective July 1, 1996; amended effective May 1, 2000; September 1, 2003; October 1, 2012; July 1, 2014; April 1, 2016; April 1, 2018.

General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-24.1-04

75-02-02-13.2. Travel expenses for medical purposes - Institutionalized individuals - Limitations.

- 1. For purposes of this section:
 - a. "Long-term care facility" means a nursing facility, intermediate care facility for individuals with intellectual disabilities, or swing-bed facility; and
 - b. "Medical center city" means Bismarck, Devils Lake, Dickinson, Fargo, Grand Forks, Jamestown, Minot, and Williston, and includes any city that shares a common boundary with any of those cities.
- 2. A long-term care facility may not charge a resident for the cost of travel provided by the facility. Except as provided in subsection 4, a long-term care facility shall provide transportation to and from any provider of necessary medical services located within, or at no greater distance than the distance to, the nearest medical center city. Distance must be calculated by road miles.

3. If the resident has to travel farther than the nearest medical center city, the costs of travel may be reimbursed by Medicaid according to the appropriate fee schedule. Distance must be calculated by map miles.
4. A long-term care facility is not required to pay for transportation by ambulance for emergency or nonemergency situations for residents.
5. A service provider that is paid a rate, determined by the department on a cost basis that includes transportation service expenses, however denominated, may not be compensated as a transportation service provider for transportation services provided to an individual residing in the provider's facility. The following service providers may not be so compensated:
 - a. Basic care facilities;
 - b. Residential habilitation services for individuals with intellectual or developmental disabilities;
 - c. Group homes serving children in foster care;
 - d. Intermediate care facilities for individuals with intellectual disabilities;
 - e. Independent habilitation services for individuals with intellectual or developmental disabilities;
 - f. Nursing facilities;
 - g. Psychiatric residential treatment facilities;
 - h. Residential child care facilities; and
 - i. Swing-bed facilities.
6. If, under the circumstances, a long-term care facility is not required to transport a resident, and the facility does not actually transport the resident, the availability of transportation services and payment of travel expenses is governed by section 75-02-02-13.1.

History: Effective July 1, 1996; amended effective July 1, 2012; October 1, 2012; April 1, 2016; April 1, 2018.

General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-24.1-04

75-02-02-14. County administration.

1. Except as provided in subsection 2, the county where the medical assistance unit is physically present is responsible for the administration of the program with respect to that unit.
2. When a unit receiving assistance moves from one county to another, the outgoing county continues to be responsible for the administration of the program with respect to that unit until the last day of the month after the month in which the unit assumes physical residence in an incoming county.

History: Effective November 1, 1983; amended effective July 1, 1984; May 1, 1986; May 1, 2000; October 1, 2012.

General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-01.2-03

75-02-02-15. Groups covered.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-16. Basic eligibility factors.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-17. Blindness and disability.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-18. Financial eligibility.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-19. Income and resource considerations.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-20. Income levels and application.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-21. Property resource limits.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-22. Exempt property resources.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-23. Excluded property resources.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-24. Contractual rights to receive money payments.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-25. Disqualifying transfers.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-26. Eligibility under 1972 state plan.

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

75-02-02-27. Scope of drug benefits - Prior authorization.

1. Prior authorization means a process requiring the prescriber or the dispenser to verify with the department or the department's contractor that proposed medical use of a particular drug for a medical assistance program recipient meets predetermined criteria for coverage by the medical assistance program.
2. A prescriber or a dispenser must secure prior authorization from the department or its designee as a condition of payment for those drugs subject to prior authorization.
3. A prescriber or a dispenser must provide to the department or its designee in the format required by the department the data necessary for the department or its designee to make a decision regarding prior authorization. The department shall deny a claim for coverage of a drug requiring prior authorization if the prescription was dispensed prior to authorization or if the required information regarding the prior authorization is not provided by the prescriber or the dispenser.
4. A prescriber or dispenser must submit a request for prior authorization to the department or its designee by telephone, facsimile, electronic mail, or in any other format designated by the department. The department or its designee must respond to a prior authorization request within twenty-four hours of receipt of a complete request that contains all of the data necessary for the department to make a determination.
5. Emergency supply.
 - a. If a recipient needs a drug before a prescriber or dispenser can secure prior authorization from the department, the department shall provide coverage of the lesser of a five-day supply of a drug or the amount prescribed if it is not feasible to dispense a five-day supply because the drug is packaged in such a way that it is not intended to be further divided.
 - b. The department will not provide further coverage of the drug beyond the five-day supply unless the prescriber or dispenser first secures prior authorization from the department.
6. The department must authorize the provision of a drug subject to prior authorization if:
 - a. Other drugs not requiring prior authorization have not been effective or with reasonable certainty are not expected to be effective in treating the recipient's condition;
 - b. Other drugs not requiring prior authorization cause or are reasonably expected to cause adverse or harmful reactions to the health of the recipient; or
 - c. The drug is prescribed for a medically accepted use supported by a compendium or by approved product labeling unless there is a therapeutically equivalent drug that is available without prior authorization.

7. If a recipient is receiving coverage of a drug that is later subject to prior authorization requirements, the department shall continue to provide coverage of that drug until the prescriber must reevaluate the recipient. The department will provide a form by which a prescriber may inform the department of a drug that a recipient must continue to receive beyond the prescription reevaluation period regardless of whether such drug requires prior authorization. The form shall contain the following information:
 - a. The requested drug and its indication;
 - b. An explanation as to why the drug is medically necessary; and
 - c. The signature of the prescriber confirming that the prescriber has considered generic or other alternatives and has determined that continuing current therapy is in the best interest for successful medical management of the recipient.

8. If a recipient under age twenty-one is prescribed five or more concurrent prescriptions for antipsychotics, antidepressants, anticonvulsants, benzodiazepines, mood stabilizers, sedative, hypnotics, or medications used for the treatment of attention deficit hyperactivity disorder, the department shall require prior authorization of the fifth or more concurrent drug. Once the prescriber of the fifth or more concurrent drug consults with a board-certified pediatric psychiatrist regarding the overall care of the recipient, and if that prescriber wishes to still prescribe the fifth or more concurrent drug, the department will grant authorization for the drug.

History: Effective September 1, 2003; amended effective July 26, 2004; July 1, 2006; October 1, 2012; April 1, 2018.

General Authority: NDCC 50-24.6-10

Law Implemented: NDCC 50-24.6; 42 USC 1396r-8

75-02-02-28. Drug use review board and appeals.

1. The department shall implement a prospective and retrospective drug use review program for outpatient prescription drugs and determine which drugs shall be subject to prior authorization before payment will be approved. The department shall consider the advice and recommendations of the drug use review board before requiring prior authorization of any drug.

2. The drug use review board shall:
 - a. Cooperate with the department to implement a drug use review program;
 - b. Receive and consider information regarding the drug use review process which is provided by the department and interested parties, including prescribers who treat significant numbers of recipients;
 - c. Review and make recommendations to the department regarding drugs to be included on prior authorization status;
 - d. Review no less than once each year the status of the drugs that have been deemed to require prior authorization and make recommendations to the department regarding any suggested changes;
 - e. Review and approve the prior authorization program process used by the department, including the process to accommodate the provision of a drug benefit in an emergency situation;

- f. Advise and make recommendations to the department regarding any rule proposed for adoption by the department to implement the provisions of state and federal law related to drug use review; and
 - g. Propose remedial strategies to improve the quality of care and to promote effective use of medical assistance program funds or recipient expenditures.
3. The drug use review board may establish a panel of physicians and pharmacists to provide guidance and recommendations to the board in considering specific drugs or therapeutic classes of drugs to be included in the prior authorization program.
 4. The drug use review board shall make a recommendation to the department regarding prior authorization of a drug based on:
 - a. Consideration of medically and clinically significant adverse side effects, drug interactions and contraindications, assessment of the likelihood of significant abuse of the drug, and any other medically and clinically acceptable analysis or criteria requested by the drug use review board; and
 - b. An assessment of the cost-effectiveness of the drug compared to other drugs used for the same therapeutic indication and whether the drug offers a clinically meaningful advantage in terms of safety, effectiveness, or clinical outcome over other available drugs used for the same therapeutic indication.
 5. Drug use review board meeting procedures.
 - a. Any interested party may address the drug use review board at its regular meetings if the presentation is directly related to an agenda item.
 - b. The drug use review board may establish time limits for presentations.
 - c. The department shall post on its web site the proposed date, time, location, and agenda of any meeting of the drug use review board at least thirty days before the meeting.
 6. Within thirty days of the date the drug use review board's recommendation is received by the department, the department shall review the recommendations and make the final determination as to whether a drug requires prior authorization and, if so, when the requirement for prior authorization will begin. If the department's final determination is different from the recommendation of the drug use review board, the department shall present, in writing, to the drug use review board at its next meeting the basis for the final determination.
 7. The department shall post on its web site the list of drugs subject to prior authorization and the date on which each drug became subject to prior authorization.
 8. A recipient may appeal the department's denial, suspension, reduction, or termination of a covered drug based upon application of this section as authorized under North Dakota Century Code chapter 28-32.

History: Effective September 1, 2003; amended effective October 1, 2012.

General Authority: NDCC 50-24.6-10

Law Implemented: NDCC 50-24.6; 42 USC 1396r-8

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

1. Payment may not be made for services that require a referral from a recipient's primary care provider for recipients, with the exception of recipients who are notified by the department and

are required within fourteen days from the date of that notice, but who have not yet selected, or have not yet been auto-assigned a primary care provider.

2. A primary care provider must be selected by or on behalf of the members in the following medical assistance units:
 - a. The parents or caretaker relatives and their spouses of a deprived child under the age of eighteen years, but through the month of the child's eighteenth birthday, up to fifty-four percent of the federal poverty level.
 - b. For up to twelve months, the parents or caretaker relatives, along with their spouses and dependent children, of a deprived child under the age of eighteen years, but through the month of the child's eighteenth birthday, who were eligible under the parents and caretaker relatives and their spouses category in at least three of the six months immediately preceding the month in which the parents or caretakers lose coverage under the parents and caretaker relatives and their spouses category due to increased earned income or hours of employment.
 - c. For up to four months, the parents or caretaker relatives, along with their spouses and dependent children, of a deprived child under the age of eighteen years, but through the month of the child's eighteenth birthday, who were eligible under the parents and caretaker relative and their spouses category in at least three of the six months immediately preceding the month in which the parents or caretaker relatives lose coverage under the parents and caretaker relatives and their spouses category due to increased alimony or spousal support.
 - d. A pregnant woman up to one hundred forty-seven percent of the federal poverty level.
 - e. An eligible woman who applied for and was eligible for Medicaid during pregnancy continues to be eligible for sixty days, beginning on the last day of pregnancy, and for the remaining days of the month in which the sixtieth day falls.
 - f. A child born to an eligible pregnant woman who applied for and was found eligible for Medicaid on or before the day of the child's birth, for twelve months, beginning on the day of the child's birth and for the remaining days of the month in which the twelfth month falls.
 - g. A child, not including a child in foster care, from birth through five years of age up to one hundred forty-seven percent of the federal poverty level.
 - h. A child, not including a child in foster care, from six through eighteen years of age, up to one hundred thirty-three percent of the federal poverty level.
 - i. A child, not including a child in foster care, from six through eighteen years of age who becomes Medicaid eligible due to an increase in the Medicaid income levels used to determine eligibility.
 - j. An individual who is not otherwise eligible for Medicaid and who was in title IV-E funded, state-funded, or tribal foster care in this state under in the month the individual reaches eighteen years of age, through the month in which the individual reaches twenty-six years of age.
 - k. A pregnant woman who requires medical services and qualifies for Medicaid on the basis of financial eligibility resulting in a recipient liability under section 75-02-02.1-41.1 and whose income is above one hundred forty-seven percent of the federal poverty level.

- I. A child less than nineteen years of age who requires medical services and qualifies for Medicaid on the basis of financial eligibility resulting in a recipient liability under section 75-02-02.1- 41.1 and whose income is above one hundred seventy percent of the federal poverty level.
 - m. The parents and caretaker relatives and their spouses of a deprived child who require medical services and qualify for Medicaid on the basis of financial eligibility resulting in a recipient liability under section 75-02-02.1-41.1 and whose income is above one hundred thirty-three percent of the federal poverty level.
3. A physician, nurse practitioner, or physician assistant practicing in the following specialties or the following entities may be selected as a primary care provider:
 - a. Family practice;
 - b. Internal medicine;
 - c. Obstetrics;
 - d. Pediatrics;
 - e. General practice;
 - f. A rural health clinic;
 - g. A federally qualified health center; or
 - h. An Indian health services clinic or tribal health facility clinic.
4. A recipient need not select, or have selected on the recipient's behalf, a primary care provider if:
 - a. The recipient is aged, blind, or disabled;
 - b. The period for which benefits are sought is prior to the date of application;
 - c. The recipient is receiving foster care or subsidized adoption benefits;
 - d. The recipient is receiving home and community-based services; or
 - e. The recipient has been determined medically frail under section 75-02-02.1-14.1.
5. Payment may be made for the following medically necessary covered services whether or not provided by, or upon referral from, a primary care provider:
 - a. Early and periodic screening, diagnosis, and treatment of recipients under age twenty-one;
 - b. Family planning services;
 - c. Certified nurse midwife services;
 - d. Optometric services;
 - e. Chiropractic services;
 - f. Dental services;

- g. Orthodontic services provided as the result of a referral through the early and periodic screening, diagnosis, and treatment program;
 - h. Services provided by an intermediate care facility for individuals with intellectual disabilities;
 - i. Emergency services;
 - j. Transportation services;
 - k. Targeted case management services;
 - l. Home and community-based services;
 - m. Nursing facility services;
 - n. Prescribed drugs except as otherwise specified in section 75-02-02-27;
 - o. Psychiatric services;
 - p. Ophthalmic services;
 - q. Obstetrical services;
 - r. Behavioral health services;
 - s. Services for treatment of addiction;
 - t. Partial hospitalization for psychiatric services;
 - u. Ambulance services;
 - v. Immunizations;
 - w. Independent laboratory and radiology services;
 - x. Public health unit services; and
 - y. Personal care services.
6. Except as provided in subsection 4, or unless the department exempts the recipient, a primary care provider must be selected for each recipient.
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 twelve months during the sixty-day open enrollment period, or with good cause. Good cause for changing a primary care provider less than twelve 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 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; April 1, 2016; January 1, 2017; April 1, 2018.

General Authority: NDCC 50-24.1-04

Law Implemented: NDCC 50-24.1-32; 42 USC 1396u-2