CHAPTER 75-02-02
MEDICAL SERVICES

SECTION 1. Section 75-02-02-03.2 is amended as follows:

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 twenty-one years of age. 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.

~~2.~~3. "County agency" means the county social service board.

~~3.~~4. "Department" means the North Dakota department of human services.

~~4.~~5. "Drug use review board" means the board established pursuant to North Dakota Century Code chapter 50-24.6.

~~5.~~6. "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.

~~6.~~7. "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.

~~7.~~8. "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.

~~8.~~9. "Medically necessary" includes only medical or remedial services or supplies required for treatment of illness, injury, diseased condition, or impairment; consistent with the patient's diagnosis or symptoms; appropriate according to generally accepted standards of medical practice; not provided only as a convenience to the patient 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.

~~9.~~10. "Provider" means an individual, entity, or facility furnishing medical or remedial services or supplies pursuant to a provider agreement with the department.

~~10.~~11. "Psychiatric residential treatment facility" is as defined in subsection 10 of section 75-03-17-01.

~~11. "Psychological service" means a psychological evaluation, therapy, or testing service rendered by a 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, or licensed certified social worker.~~

12. "Recipient" means an individual approved as eligible for medical assistance.

13. "Rehabilitative services" means any medical remedial items or services prescribed for a patient by the patient'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 patient to the patient's best possible functional level.

14. "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.

15. "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.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-01

Section 2. Section 75-02-02-08 is amended as follows:

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

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

   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 which 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 patient 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 patient 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 and diagnosis of individuals under twenty-one years of age and treatment of conditions found. Early and periodic screening and diagnosis of individuals under the age of twenty-one who are eligible under the plan to ascertain their physical or mental defects, and provide health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Federal financial participation is available for any item of medical or remedial care and services included under this subsection for individuals under the age of twenty-one. Such care and services may be provided under the

plan to individuals under the age of twenty-one, even if such care and services are not provided, or are provided in lesser amount, duration, or scope to individuals twenty-one years of age or older.

g. Physician's services. "Physician's services" whether furnished in the office, the patient'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 patients in their homes and described elsewhere in this section, means any of the following items and services when they are provided, based on certification of need and a written plan of care by a licensed physician, to a patient in the patient'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 U.S.C. 1395x(dd)(1) furnished by a "hospice program", as that term is defined in 42 U.S.C.1395x(dd)(2), 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 which are consistent with procedures established under 42 U.S.C. 1395d(d)(2), for such periods of time as the department may establish, and may be revoked at any time.

k. Private duty nursing services. "Private duty nursing services" means nursing services provided, based on certification of need and a written plan of care which is provided under the direction of a physician, by a registered nurse or a licensed practical nurse under the supervision of a registered nurse to a patient in the patient's own home.

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 patient 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 patient 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 patient 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 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 patient 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 patient 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 patient by the patient'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 patient.

(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 remedial items or services prescribed for a patient by the patient'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 patient to the patient'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 or to identify suspects for more definitive studies.

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 section75-02-02-10.

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) 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 patient from other sources.

w. An exercise program. "Exercise program" includes exercise regimens to achieve various improvements in physical fitness and health.

x. A weight loss program. "Weight loss program" includes programs designed for reduction in weight but does not include weight loss surgery.

y. 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. Services are limited to the home of the recipient.

(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.

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. 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 section75-02-02-12.

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:

(1) The lower of the estimated acquisition costs plus reasonable dispensing fees established by the department;

(2) The provider's usual and customary charges to the general public; or

(3) The federal upper limit or maximum allowable cost plus reasonable dispensing fees established by the department. For the department to meet the requirements of 42 CFR 447.331-447.333, pharmacy providers agree when enrolling as a provider to fully comply with any acquisition cost survey and any cost of dispensing survey completed for the department or centers for medicare and medicaid services. Pharmacy providers agree to provide all requested data to the department, centers for medicare and medicaid services, or their agents, to allow for calculation of estimated acquisition costs for drugs as well as estimated costs of dispensing. This data will include wholesaler invoices and pharmacy operational costs. Costs can include salaries, overhead, and primary wholesaler invoices if a wholesaler is partially or wholly owned by the pharmacy or parent company or has any other relationship to the pharmacy provider.

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.

c. The department may refuse payment for any covered service or procedure provided to an individual eligible for both medicaid and other insurance if the insurance denies payment because of the failure of the provider or recipient to comply with the requirements of the other insurance.

5. A provider of medical services who provides a covered service except for personal care services, but fails to receive payment due to the requirements of subsection 4, and 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 agreement referred to in subsection 4 of section 75-02-02-10.

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.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 USC 1396n(b)(1); 42 CFR 431.53; 42 CFR 431.110; 42 CFR 435.1009; 42 CFR Part 440; 42 CFR Part 441, subparts A, B, D

Section 3. Section 75-02-02-09.1 is amended as follows:

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 that are not elective or not urgent; 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. ~~Three dollars for each nonemergency visit to a hospital emergency room;~~

~~c.~~ Two dollars for each office visit for care by a physician, nurse practitioner, physician assistant, nurse midwife, clinical nurse specialist, optometrist, or chiropractor;

~~d.~~c. Three dollars for each office visit to a rural health clinic or federally qualified health center;

~~e.~~d. One dollar for each chiropractic manipulation of the spine;

~~f.~~e. Two dollars for each dental visit that includes an oral examination;

~~g.~~f. Three dollars for each brand name prescription filled;

~~h.~~g. Two dollars for each optometric visit that includes a vision examination;

~~i.~~h. Three dollars for each podiatric office visit;

~~j.~~i. Two dollars for each occupational therapy visit;

~~k.~~j. Two dollars for each physical therapy visit;

~~l.~~k. One dollar for each speech therapy visit;

~~m.~~l. Three dollars for each hearing aid dispensing service;

~~n.~~m. Two dollars for each audiology testing visit;

~~o.~~n. Two dollars for each ~~psychological~~ behavioral health service visit; and

~~p.~~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.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

Section 4. Section 75-02-02-09.4 is amended as follows:

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 occupational therapy evaluation except one per calendar year or for occupational therapy provided to ~~an individual~~ 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. ~~This limit does not apply to school-based services for children.~~

b. No payment will be made for physical therapy evaluation except one per calendar year or for physical therapy provided to ~~an individual~~ 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. ~~This limit does not apply to school based services for children.~~

c. No payment will be made for speech therapy evaluation except one per calendar year or for speech therapy provided to ~~an individual~~ 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. ~~This limit does not apply to school-based services for children.~~

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~~; or~~.

b. No payment will be made for psychological evaluations except for one per calendar year~~; or~~.

c. No payment will be made for psychological testing except for four units per calendar year ~~for services rendered by licensed independent clinical social workers, psychologists, licensed addiction counselors, licensed associate professional counselors, licensed professional counselors, licensed professional clinical counselors, licensed social workers, and licensed certified social workers unless the provider requests and receives the prior approval of the department. Limits in this subsection do not apply to services provided by staff employed by schools, residential child care facilities, treatment foster care providers, or human service centers~~.

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 specialist, physician assistant, or nurse practitioner. 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.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

Section 5. Section 75-02-02-29 is amended as follows:

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

1. Payment may not be made, except as provided in this subsection, for otherwise covered services provided to otherwise eligible recipients:

   a. Who are required by this subsection to select, but who have not selected, or have not had selected on their behalf, a primary care provider; or

   b. By a provider who is not the primary care provider selected by or on behalf of the recipient or to whom the recipient has not been referred from the 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.

l. 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, practices, or settings 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.

4. A recipient identified in subsection 2 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 the intellectually disabled;

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. ~~Psychological~~ Behavioral health services;

s. Ambulance services;

t. Immunizations;

u. Independent laboratory and radiology services;

v. Public health unit services; and

w. 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 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.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-32; 42 USC 1396u-2