CHAPTER 75-02-02
MEDICAL SERVICES

75-02-02-27 Scope of Drug Benefits - Prior Authorization
75-02-02-28 Drug Use Review Board and Appeals
75-02-02-29 Primary Care Provider

SECTION 1. Subsection 1 of section 75-02-02-08 is amended as follows:

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 and children's health insurance program 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 Medicaid or children's health insurance program.

   (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.

x. Interpreter services. “Interpreter services” means services that assist clients with sign or oral language interpreter services for assistance in providing covered health care services to a recipient of medical assistance who has limited English proficiency or who has hearing loss and uses interpreter services.

History: Amended effective September 1, 1978; September 2, 1980; February 1, 1981; November 1, 1983; May 1, 1986; November 1, 1986; November 1, 1987; January 1, 1991; July 1, 1993; January 1, 1994; January 1, 1996; July 1, 1996; January 1, 1997; May 1, 2000; amendments partially voided by the Administrative Rules Committee effective June 5, 2000; November 8, 2002; September 1, 2003; July 1, 2006; January 1, 2010; July 1, 2012; October 1, 2012; July 1, 2014; April 1, 2016; January 1, 2017; April 1, 2018; April 1, 2020; January 1, 2022.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 USC 1396n(b)(1); 42 CFR 431.53; 42 CFR 431.110; 42 CFR 435.1009; 42 CFR Part 440; 42 CFR Part 441, subparts A, B, D

SECTION 2. Section 75-02-02-09.4 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 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~~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 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~~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 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~~twenty 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~~advanced practice registered nurses. 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; January 1, 2022.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04

SECTION 3. Section 75-02-02-09.5 is amended as follows:

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~~may be made to a provider who lives with the client and is a relative, other than a legal spouse, 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 if the activity exclusively benefits the client.

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~~ to a 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~~who has natural supports.

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; January 1, 2022.
General Authority: NDCC 50-24.1-18
Law Implemented: NDCC 50-24.1-18; 42 CFR Part 440.167

SECTION 4. Section 75-02-02-10.1 is repealed.

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

[Repealed effective January 1, 2022]

~~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~~

SECTION 5. Section 75-02-02-10.2 is amended as follows:

75-02-02-10.2. Limitations on services for treatment of ~~addiction~~substance use disorder.

1. For purposes of this section:

   a. "~~American Society of Addiction Medicine I~~Outpatient services" means services for treatment of ~~addiction~~substance use disorder as prescribed in ~~article 75-09.1~~chapters 75-09.1-07 and 75-09.1-07.1.

   b. "~~American Society of Addiction Medicine II.1~~Intensive outpatient treatment" means services for treatment of ~~addiction~~substance use

disorder as prescribed in ~~article 75-09.1~~chapters 75-09.1-06 and 75-09.1-06.1.

c. "~~American Society of Addiction Medicine II.5~~Partial hospitalization" means services for treatment of ~~addiction~~substance use disorder as prescribed in ~~article 75-09.1~~chapters 75-09.1-05 and 75-09.1-05.1.

d. "~~American Society of Addiction Medicine III.1~~Clinically managed low-intensity residential care" means services for treatment of ~~addiction~~substance use disorder as prescribed in ~~article 75-09.1~~chapters 75-09.1-02 and 75-09.1-02.1.

e. "Clinically managed residential withdrawal" means services for treatment of substance use disorder as prescribed in chapter 75-09.1-08.

f. "~~American Society of Addiction Medicine III.5~~Clinically managed high-intensity residential care" means services for treatment of ~~addiction~~substance use disorder as prescribed in ~~article 75-09.1~~chapters 75-09.1-03 and 75-09.1-03.1.

g. "Medically monitored intensive inpatient treatment" means services for treatment of substance use disorder as prescribed in chapters 75-09.1-04 and 75-09.1-04.1.

~~f.~~h. "Services for treatment of ~~addiction~~substance use disorder" means ~~ambulatory~~ services provided to an individual with an impairment resulting from ~~an addictive~~a substance use 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~~substance use disorder may be hospital-based or nonhospital-based.

2. Limitations.

~~a. Payment may not be made for American Society of Addiction Medicine II.1 services exceeding thirty days per calendar year per recipient.~~

~~b. Payment may not be made for American Society of Addiction Medicine II.5 services exceeding forty-five days per calendar year per recipient.~~

~~c. Payment may not be made for American Society of Addiction Medicine III.5 services exceeding forty-five days per calendar year per recipient.~~

~~d. The department may authorize additional days per calendar year per recipient if determined to be medically necessary.~~

~~e.~~ Payment may not be made for ~~American Society of Addiction Medicine III.1~~clinically managed low-intensity residential care services, unless the recipient is concurrently receiving ~~American Society of Addiction Medicine II.1~~intensive outpatient treatment or ~~II.5~~partial hospitalization services.

3. Licensed addiction counselors, operating within their scope of practice, performing ~~American Society of Addiction Medicine I~~outpatient services, 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~~outpatient billed services provided within a recognized Indian reservation in North Dakota.

4. Licensed addiction counselor includes licensed clinical addiction counselors, licensed master addiction counselors, and practitioners possessing a similar license in a border state and operating within their scope of practice in that state.

5. Licensed addiction programs operating in a border state must provide documentation to the department of their state's approval for the operation of the addiction program.

History: Effective November 8, 2002; amended effective November 19, 2003; October 1, 2012; July 1, 2014; April 1, 2018; April 1, 2020; January 1, 2022.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 431.54

SECTION 6. Section 75-02-02-10.3 is amended as follows:

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

1. For purposes of this section:

   a. "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.

   b. "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.

c. "Partial hospitalization psychiatric services" means level A or level B 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.~~

2. ~~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 authorize additional days per calendar year per recipient if determined to be medically necessary~~only be made for partial hospitalization psychiatric services that are hospital based.

History: Effective April 1, 2018; amended effective April 1, 2020; January 1, 2022.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 431.54

SECTION 7. Section 75-02-02-27 is amended as follows:

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 Medicaid program or children's health insurance program recipient meets predetermined criteria for coverage by the Medicaid program or children's health insurance 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.

9. The department may require prior authorization if a recipient age twenty-one or over is prescribed a stimulant medication used in the treatment of attention deficit disorder and attention deficit hyperactivity disorder by an individual who prescribes this medication at a rate two times higher than the rate of the top ten prescribers excluding the top prescriber based on data representing claims processed for a time period of no less than the previous quarter and no greater than the previous twelve months.

10. The department may require prior authorization for any medication that is a line extension drug in any of the excluded medication classes under subsection 3 of section 50-24.6-04 of the North Dakota Century Code when the line extension medication's net cost is higher than the original medication due to federal drug rebate offset differences.

History: Effective September 1, 2003; amended effective July 26, 2004; July 1, 2006; October 1, 2012; April 1, 2018; April 1, 2020; January 1, 2022.
General Authority: NDCC 50-24.6-04, 50-24.6-10
Law Implemented: NDCC 50-24.6; 42 USC 1396r-8

SECTION 8. Section 75-02-02-29 is amended as follows:

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 Medicaid 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 fifty-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 fifty-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.

n. A child, not including a child in foster care, less than nineteen years of age with income up to one hundred seventy percent of the federal poverty level.

o. An individual age nineteen or twenty eligible under Medicaid expansion, as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152], and implementing regulations.

3. A physician, advanced practice registered nurse with the role of nurse practitioner, ~~or~~ physician assistant, or certified nurse midwife 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. Adult health;

g. A rural health clinic;

h. A federally qualified health center; or

i. 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. The department may not limit a recipient's disenrollment from a primary care provider. 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~~at any time upon request by the recipient.

History: Effective October 1, 2012; amended effective July 1, 2014; April 1, 2016; January 1, 2017; April 1, 2018; April 1, 2020; January 1, 2022.
General Authority: NDCC 50-24.1-04, 50-24.1-41
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