CHAPTER 75-02-05
PROVIDER INTEGRITY

75-02-05-01. Purpose.

The purpose underlying administrative remedies and sanctions in the Medicaid and children's health insurance program is to ensure the proper and efficient utilization of Medicaid and children's health insurance program funds by those individuals providing medical and other health services and goods to recipients.

History: Effective July 1, 1980; amended effective July 1, 2012; April 1, 2018.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-29-02
Law Implemented: NDCC 50-24.1-01

75-02-05-02. Authority and objective.

Under authority of North Dakota Century Code chapters 50-24.1 and 50-29, the department of human services is empowered to promulgate such rules and regulations necessary to qualify for federal funds under section 1901 specifically, title XIX and title XXI generally of the Social Security Act. These rules are subject to the Medicaid and children's health insurance program state plan and to applicable federal law, federal regulation, state law, and state rules.

History: Effective July 1, 1980; amended effective July 1, 2012; April 1, 2018.
General Authority: NDCC 50-06-01.9, 50-06-05.1, 50-24.1-04, 50-29-02
Law Implemented: NDCC 50-24.1-04

75-02-05-03. Definitions.

In this chapter, unless the context or subject matter otherwise requires:

1. "Abuse" means practices that:

   a. Are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to Medicaid and children's health insurance program;

   b. Elicit reimbursement for services that are not medically necessary;

   c. Are in violation of an agreement or certificate of coverage; or

   d. Fail to meet professionally recognized standards for health care.

2. "Administrative or fiscal agent" means an organization which processes and pays provider claims on behalf of the department.

3. "Affiliates" means persons having an overt or covert relationship each with the other such that any one of them directly or indirectly controls or has the power to control another.

4. "Business integrity agreement" means an agreement between the department and the provider that addresses the concerns of the department and recognizes essential elements of required compliance for the provider to preempt further sanction, exclusion from participation, or termination.

5. "Children's health insurance program" means a program to provide health assistance to low-income children funded through title XXI of the Social Security Act [42 U.S.C. 1397 aa et seq.].

6. "Client share" means the amount of monthly net income remaining after all appropriate deductions, disregards, and Medicaid income levels have been allowed. This is also referred to as recipient liability.

7. "Credible allegation of fraud" means an allegation which has been verified by the department.

8. "Department" means the department of human services' medical services, aging services, and developmental disabilities divisions.

9. "Direct owner" means someone with an active ownership interest in the disclosing entity.

10. "Disclosing entity" means a Medicaid or children's health insurance program provider, excluding an individual practitioner or group of practitioners, or a fiscal agent, that is required to provide ownership and enrollment information.

11. "Exclusion from participation" means permanent removal from provider participation in the North Dakota medical assistance or children's health insurance program.

12. "Fraud" means deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or another and includes an act that constitutes fraud under applicable federal or state law.

13. "Group of practitioners" means two or more health care practitioners who practice their profession at a common location.

14. "High-risk providers" means a provider or a provider type or specialty deemed by the department as high risk, based on federal regulations, policy, and guidance.

15. "Indirect ownership interest" means disclosing ownership interest in a disclosing entity, including an ownership interest in any entity that has an indirect ownership in the disclosing entity.

16. "Institutional provider" for purposes of assessing an application fee means those defined by centers for Medicare and Medicaid services or as deemed by the department based on federal regulations, policy, and guidance.

17. "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.

18. "Loss of contact" means postal mail sent to an enrolled provider at the last known address is returned to the department.

19. "Managed care organization" means an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 C.F.R. part 438, and that is:

    a. A federally qualified health management organization that meets the advance directives requirements of 42 C.F.R. 489.102; or

    b. Any public or private entity that meets the advance directives requirements and is determined by the secretary of the federal department of health and human services, or designee, to also make the services it provides to program enrollees as accessible as those services are to other Medicaid and children's health insurance program recipients within the area served by the entity and meets the solvency standards of 42 C.F.R. 438.116.

20. "Medicaid" means "medical assistance" and is a term precisely equivalent thereto.

21. "Ownership interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

22. "Person" means any natural person, company, firm, association, corporation, or other legal entity.

23. "Provider" means any individual or entity furnishing Medicaid or children's health insurance program services under a provider agreement with the department or managed care organization.

24. "Provider specialty" means the area that a provider specializes in.

25. "Provider type" means a general type of service or provider.

26. "Sanction" means an action taken by the department against a provider for noncompliance with a federal or state law, rule, or policy, or with the provisions of the Medicaid and children's health insurance program provider agreement.

27. "Suspend payments" means the withholding of payments due a provider until the matter in dispute between the provider and the department is resolved.

28. "Suspension from participation" means temporary suspension of provider participation in the Medicaid program for a specified period of time.

29. "Termination" means determining a provider to be indefinitely ineligible to be a Medicaid and children's health insurance program provider.

History: Effective July 1, 1980; amended effective July 1, 2012; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-29-02
Law Implemented: 42 CFR 431.107

75-02-05-04. Provider responsibility.

To assure quality medical care and services, Medicaid and children's health insurance program payments may be made only to providers meeting established standards. Providers who are certified for participation in Medicare are eligible for participation, providing no sanction has been imposed as provided for in section 75-02-05-07. Comparable standards for providers who do not participate in Medicare are established by state law and appropriate licensing and standard-setting authorities in the health and mental health fields.

1. Payment for services under Medicaid and children's health insurance program is limited to those covered services that are medically necessary for the proper management, control, or

treatment of an individual's medical problem and provided under the physician's or licensed practitioner's direction and supervision.

2. Each provider agrees to retain documentation to support medical services rendered for a minimum of seven years and, upon request, to make the documentation available to persons acting on behalf of the department and the United States department of health and human services. A provider shall provide the records at no charge.

3. A provider must accept, as payment in full, the amounts paid in accordance with the payment structure established by the department. A provider performing a procedure or service may not request or receive any payment, in addition to the amounts established by the department, from the recipient, or anyone acting on the recipient's behalf, for the same procedure or service. In cases where a client share has been properly determined by a human service zone, the provider may hold the recipient responsible for the client share.

4. A provider may not bill a recipient for services that are allowable under Medicaid or children's health insurance program, but not paid due to the provider's lack of adherence to Medicaid or children's health insurance program requirements.

5. If an enrolled Medicaid or children's health insurance program provider does not bill Medicaid for certain services, the enrolled Medicaid or children's health insurance program provider must notify all recipients of any limitation and secure acknowledgment, in writing. If the provider expressly informs the recipient, or in the case of a child, the recipient's parent or guardian, that provider would not accept Medicaid or children's health insurance program payment for certain services, the provider may bill the recipient as a private-pay client for the services.

6. No Medicaid or children's health insurance program payment will be made for original claims received by the department later than one hundred eighty days from the date of service. Final claim adjustments must be submitted within three hundred sixty-five days from the date of service. The department may grant a variance to extend the deadline for a provider to submit a final claim adjustment. A refusal to grant a variance is not subject to a request for review or an appeal.

7. The department will process claims within one hundred eighty days from the date on the Medicare explanation of benefits if the provider followed Medicare's timely filing policy.

8. In all joint Medicare/Medicaid cases, a provider must accept assignment of Medicare payment to receive payment from Medicaid for amounts not covered by Medicaid and children's health insurance program.

9. When the recipient has other medical insurance, all benefits available due from that other insurance must be applied prior to the provider accepting payment by Medicaid.

10. A provider may not offer or accept a fee, portion of a fee, charge, rebate, or kickback for a Medicaid or children's health insurance program patient referral.

11. Claims for payment and documentation must be submitted as required by the department or its designee.

12. A provider shall comply with all accepted standards of professional conduct and practice in dealing with recipients and the department.

13. Each provider shall comply with all applicable centers for Medicare and Medicaid services regulations.

14. Each provider shall comply with requests for documentation from the provider's practice, that may include patient information for non-Medicaid or non-children's health insurance program recipients, which allows department staff or its authorized agent to evaluate overall scheduling, patient-to-provider ratios, billing practices, or evaluating the feasibility of services provided per day.

History: Effective July 1, 1980; amended effective July 1, 2012; April 1, 2018; April 1, 2020; January 1, 2022.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-29-02
Law Implemented: 42 CFR 431.107

75-02-05-04.1. Denial of application to become a Medicaid or children's health insurance program provider.

The department may deny an application to become a Medicaid or children's health insurance program provider if:

1. The applicant voluntarily withdraws the application;

2. The applicant is not in compliance with applicable federal law, federal regulation, state law, state rules, or program issuances governing providers;

3. The applicant, if previously enrolled as a Medicaid or children's health insurance program provider, was not in compliance with the terms set forth in the application or provider agreement;

4. The applicant, if previously enrolled as a Medicaid or children's health insurance program provider, was not in compliance with the provider certification terms on the claims submitted for payment;

5. The applicant, if previously enrolled as a Medicaid or children's health insurance program provider, had demonstrated a pattern of submitting inaccurate billings or cost reports;

6. The applicant, if previously enrolled as a Medicaid or children's health insurance program provider, had demonstrated a pattern of submitting billings for services not covered under department programs;

7. The applicant has been debarred or the applicant's license or certificate to practice in the applicant's profession or to conduct business has been suspended or terminated;

8. The applicant delivers goods, supplies, or services that are of an inferior quality or are harmful to individuals;

9. The applicant has been convicted of an offense in section 75-02-05-11, which is determined by the department to have a direct bearing upon the applicant's ability to be enrolled as a Medicaid or children's health insurance program provider, or the department determines, following conviction of any other offense, the applicant is not sufficiently rehabilitated;

10. The applicant, if previously enrolled as a Medicaid or children's health insurance program provider, owes the department money for payments incorrectly made to the provider;

11. The provider is currently excluded from participation in Medicare, Medicaid, children's health insurance program, or any other federal health care program; and

12. For good cause.

History: Effective April 1, 2018.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-29-02

Law Implemented: 42 CFR 431.107

75-02-05-04.2. Termination of provider enrollment.

The department may terminate the enrollment of a Medicaid or children's health insurance program provider under the following circumstances:

1. The individual is enrolled to provide transportation, but does not possess a current driver's license or has a driver's license that has been suspended or revoked;

2. The enrolled provider fails to revalidate its enrollment per federal requirements and according to the re-enrollment schedule established by the department;

3. The enrolled provider or practitioner does not submit a Medicaid or children's health insurance program claim to the department for twenty-four months or more;

4. There is a loss of contact with the enrolled provider; or

5. As a result of sanction imposed in accordance with section 75-02-05-07 or North Dakota Century Code chapter 50-24.8.

History: Effective April 1, 2020.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-24.1-36, 50-29-02
Law Implemented: NDCC 50-24.1-36; 42 CFR 431.107

75-02-05-05. Grounds for sanctioning providers.

Sanctions may be imposed by the department against a provider who:

1. Presents or causes to be presented for payment any false or fraudulent claim for care or services.

2. Submits or causes to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

3. Submits or causes to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

4. Submits or causes to be submitted false, intentionally misleading, or fraudulent information in an application status for provider status under the Medicaid or children's health insurance program or any quality review or other submission required to maintain enrollment.

5. Fails to disclose or make available to the department or its authorized agent records of services provided to Medicaid and children's health insurance program recipients and records of payments received for those services; or fails to make available records from the provider's practice that allows department staff to evaluate overall scheduling, patient-to-provider ratios, review billing practices, or evaluate the feasibility of services provided per day.

6. Submits a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or department's representative or to any other publicly or privately funded health care program.

7. Fails to provide and maintain services to Medicaid and children's health insurance program recipients within accepted medical and industry standards. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to Medicaid and children's health insurance program recipients within accepted medical community standards as adjudged by professional peers, if applicable. For purposes of this subsection, "quality

services" mean services provided in accordance with the applicable rules and regulations governing the services.

8. Fails to comply with the terms of the Medicaid provider agreement or provider certification which is printed on the Medicaid claim form.

9. Overutilizes the Medicaid and children's health insurance program by inducing, furnishing, or otherwise causing a recipient to receive care and services that are not medically necessary.

10. Rebates or accepts a fee or portion of a fee or charge for a Medicaid and children's health insurance program patient referral.

11. Is convicted of a criminal offense arising out of the practice of medicine.

12. Fails to comply and to maintain compliance with all regulations and statutes, both state and federal, which are applicable to the provider's profession, business, or enterprise.

13. Is excluded from Medicare.

14. Is suspended, excluded from participation, terminated, or sanctioned by any other state's Medicaid and children's health insurance program.

15. Is suspended or involuntarily terminated from participation in any governmentally sponsored medical program.

16. Bills or collects from the recipient any amount in violation of section 75-02-05-04.

17. Fails to correct deficient provider operations within a reasonable time, not to exceed thirty days, after receiving written notice of these deficiencies from the department, another responsible state agency, or their designees.

18. Is formally reprimanded or censured by an association of the provider's peers for unethical practices.

19. Fails to change or modify delivery patterns and services within a reasonable period after receipt of a request so to do by a peer review committee whose jurisdiction includes the provider.

20. Is convicted of a criminal offense arising out of the making of false or fraudulent statements or of an omission of fact for the purpose of securing any governmental benefit to which the provider is not entitled, or out of conspiring, soliciting, or attempting such an action.

21. Refuses to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments. A refusal of repayment exists if no repayment or arrangement for repayment is made within thirty days of the date written notice of discrepancy was sent.

22. Is served with a search warrant by a member of any law enforcement agency for the purpose of obtaining evidence of a crime of fraud committed by that provider against the Medicaid or children's health insurance program, or is charged with such a crime, provided that no provider may be terminated from participation in the Medicaid or children's health insurance program on such grounds.

23. Refuses to attend a department educational program or fails to agree to implement a business integrity agreement, if required by the department.

24. Defrauds any health care benefit program.

History: Effective July 1, 1980; amended effective November 1, 1983; July 1, 2012; April 1, 2018.

General Authority: NDCC 50-06-1.9, 50-24.1-04, 50-29-02
Law Implemented: NDCC 12.1-11-02; 42 CFR 455.13, 42 CFR 455.16, 42 CFR 431.107

75-02-05-06. Reporting of violations and investigation.

1. Information from any source indicating that a provider has failed or is failing to fulfill the provider's responsibilities, as set forth in section 75-02-05-04; or that a provider has acted in a manner which forms a ground for sanction as set forth in section 75-02-05-05 must be transmitted to the department.

2. The department shall investigate the matter and, if the report is substantiated, shall take whatever action or impose whatever sanction is most appropriate. The taking of any action or the imposition of any sanction does not preclude subsequent or simultaneous civil or criminal court action.

3. a. The department may investigate suspected fraud or abuse. The department may conduct an investigation to determine whether:

   (1) Fraud or abuse exists and can be substantiated;

   (2) Sufficient evident exists to support the recovery of overpayments or the imposition of sanctions; or

   (3) The matter should be referred for action by another agency, including a law enforcement agency, to determine whether sufficient evidence exists to pursue any other civil or criminal action permitted by law.

   b. The department may undertake an investigation to:

   (1) Examine a provider's medical, financial, or patient records;

   (2) Interview a provider and a provider's associates, agents, or employees;

   (3) Verify a provider's professional credentials and the credentials of the provider's associates, agents, and employees;

   (4) Interview recipients;

   (5) Examine equipment, prescriptions, supplies, or other items used in a recipient's treatment;

   (6) Sample a random mix of paid claims, prior authorizations, and medical records;

   (7) Determine whether services provided to a recipient were medically necessary;

   (8) Examine insurance claims or records or records of any other source of payment, including recipient payments; or

   (9) The department may refer the case to the appropriate authority for further investigation and prosecution.

4. The department may contract with specialists outside the department as part of the investigation.

History: Effective July 1, 1980; amended effective July 1, 2012; April 1, 2018.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 455.14; 42 CFR 455.15; 42 CFR 455.16

75-02-05-07. Activities leading to and including sanction.

1. a. When the department determines that a provider has been rendering care or services in a form or manner inconsistent with program requirements or rules, or has received payment for which the provider may not be properly entitled, the department shall notify the provider in writing of the discrepancy noted. The notice to the provider may set forth:

   (1) The nature of the discrepancy or inconsistency.

   (2) The dollar value, if any, of such discrepancy or inconsistency.

   (3) The method of computing such dollar values.

   (4) Further actions which the department may take.

   (5) Any action which may be required of the provider.

   b. When the department has notified the provider in writing of a discrepancy or inconsistency, it may withhold payments on pending and future claims awaiting a response from the provider.

2. If the department determines that a provider's claims were not submitted properly or that a provider has engaged in suspected fraud or abuse, the department may require the provider to participate in and complete an educational program.

   a. If the department decides that a provider should participate in an educational program, the department shall provide written notice to the provider, by certified mail, setting forth the following:

   (1) The reason the provider is being directed to attend the educational program;

   (2) The educational program determined by the department; and

   (3) That continued participation as a provider in Medicaid and children's health insurance program is contingent upon completion of the educational program identified by the department.

   b. An educational program may be presented by the department. The educational program may include:

   (1) Instruction on the correct submission of claims;

   (2) Instruction on the appropriate utilization of services;

   (3) Instruction on the correct use of provider manuals;

   (4) Instruction on the proper use of procedure codes;

   (5) Education on statutes, rules, and regulations governing the Medicaid and children's health insurance program;

   (6) Education on reimbursement rates and payment methodologies;

   (7) Instructions on billing or submitting claims; and

   (8) Other educational tools identified by the department.

3. If a provider who is required to participate in an educational program refuses to participate in that program, the department shall suspend the provider from participation in Medicaid and

children's health insurance program until the provider successfully completes the required program. The time frame to successfully complete the educational program may be extended upon provider request and with department approval.

4. If the department determines that a provider's claims were not submitted properly or that a provider has engaged in suspected fraud or abuse, the department may require the provider to implement a business integrity agreement. If the department requires a provider to enter a business integrity agreement and the provider refuses, the department shall ensure the provider is suspended from participation in Medicaid and children's health insurance program until the provider implements the required agreement.

5. The department shall suspend payments to a provider after the department determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid and children's health insurance program unless the provider has demonstrated good cause why the department should not suspend payments or should suspend payment only in part. If the provider also is enrolled in a managed care organization under contract with the department, the managed care organization must suspend all Medicaid payments to the provider.

6. The department may not make payments to a provider that is not complying with a department-directed repayment plan. Recoveries may be taken across any Medicaid program payment and delivery system.

7. The director of the medical services division, or the director's designee, shall determine the appropriate sanction for a provider under this chapter. The following may be considered in determining the sanction to be imposed:

   a. Seriousness of the provider's offense.

   b. Extent of the provider's violations.

   c. Provider's history of prior violations.

   d. Prior imposition of sanctions against the provider.

   e. Prior provision of information and training to the provider.

   f. Provider's agreement to make restitution to the department.

   g. Actions taken or recommended by peer groups or licensing boards.

   h. Access to care for recipients.

   i. Provider's self-disclosure or self-audit discoveries.

   j. Provider's willingness to enter a business integrity agreement.

8. When a provider has been excluded from the Medicare program, the provider will also be terminated or excluded from participation in the Medicaid and children's health insurance program.

9. If the division determines there is a credible allegation of fraud, the division may impose any one or a combination of the following temporary sanctions:

   a. Prepayment review of claims;

   b. Postpayment review of claims;

   c. Recovery of costs associated with an investigation;

d. Requirement of a provider self-audit;

e. Notification and referral to the appropriate state regulatory agency or licensing agency;

f. Suspension from participation in the Medicaid or children's health insurance program, including providers operating under an arrangement with a managed care organization;

g. Suspend payments to a provider;

h. Prior authorization of all services; and

i. Peer review at the provider's expense.

10. After the completion of a further investigation, the department shall document its findings in writing and provide a copy of that documentation to the provider. Following a determination by the department that the provider has engaged in fraud or abuse; the department may terminate, exclude or impose sanctions with conditions, including the following:

a. Recovery of overpayments;

b. Recovery of excess payments;

c. Recovery of costs associated with an investigation;

d. Requirement of a provider self-audit;

e. Prepayment review of claims;

f. Postpayment review of claims;

g. Notification and referral to the appropriate state regulatory agency or licensing agency;

h. Prior authorization of all services;

i. Penalties as established by the department; and

j. Peer review at the provider's expense.

11. A sanction may be applied to all known affiliates of a provider, provided that each sanctioned affiliate knew or should have known of the violation.

12. A provider subject to termination or exclusion from participation may not submit claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association to the department, its fiscal agent or managed care organization for any services or supplies provided under the Medicaid or children's health insurance program except for any services or supplies provided prior to the effective date of the termination or exclusion.

13. A clinic, group, corporation, or other organization which is a provider may not submit claims for payment to the department or its fiscal agent for any services or supplies provided by a person within the clinic, group, corporation, or organization who has been terminated or is under exclusion from participation in this state or any other state or who has been excluded from Medicare except for those services or supplies provided prior to the effective date of the termination or exclusion.

14. When the department determines there is a need to sanction a provider, the director of the medical services division, or the director's designee, shall notify the provider in writing of the sanction imposed. The notice must advise the provider of the right to a review, when applicable.

15. After the department sanctions a provider, the director of the medical services division may notify the applicable professional society, board of registration or licensure, and any appropriate federal, state, human service zone, or county agency of the reasons for the sanctions and the sanctions imposed.

16. If the department sanctions a provider who also serves as a billing agent for other providers, the department may also impose sanctions against the other providers upon a finding that the actions performed as the billing agent fails to meet department standards.

History: Effective July 1, 1980; amended effective July 1, 2012; April 1, 2014; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-24.1-36, 50-29-02
Law Implemented: NDCC 50-24.1-04, 50-24.1-36; 42 CFR 455.13, 42 CFR 455.14, 42 CFR 455.15, 42 CFR 455.16, 42 CFR 455.17, 42 CFR 455.23

75-02-05-08. Imposition and extent of sanction.

Repealed effective July 1, 2012.

75-02-05-09. Review and appeal.

1. A provider may not request a review of a temporary sanction until further investigation has been completed and the department has made a final decision.

2. After completion of further investigation, if there is an imposition of a subsequent sanction, the provider may request a review of the sanction pursuant to subsection 6 of North Dakota Century Code section 50-24.1-36.

3. A provider who is aggrieved by the decision the department issues in response to a request for review may appeal as set forth in subsection 6 of North Dakota Century Code section 50-24.1-36.

4. An applicant may appeal a decision to deny enrollment or terminate provider enrollment by filing a written appeal with the department within fifteen days of the date of the written notice of the denial or termination. Upon receipt of a timely appeal, an administrative hearing may be conducted in the manner provided in chapter 75-01-03. An applicant who receives notice of denial and requests a timely review of that decision is not eligible to provide services until a final decision has been made by the department that reverses the decision to deny the application.

History: Effective July 1, 1980; amended effective July 1, 2012; April 1, 2014; April 1, 2018; April 1, 2020.
General Authority: NDCC 50-06-01.9, 50-09-02, 50-24.1-04
Law Implemented: NDCC 23-01-03, 23-16-01, 23-17.1-01, 23-20.1-04, 23-27-01, 25-16-02, 26.1-18-02, 43-05-09, 43-06-08, 43-12.1-03, 43-13-15, 43-15-15, 43-17-34, 43-26-13, 43-28-10, 43-32-17, 43-33-02, 43-37-03, 50-11.1-03, 50-24.1-36; NDAC 75-01-03; 42 USC 1396a(a)(39); 42 CFR 431.151; 42 CFR 455.13

75-02-05-10. Provider information sessions.

Repealed effective July 1, 2012.

75-02-05-11. Fingerprint-based criminal background checks.

1. The department shall provide fingerprint-based criminal background checks screenings for enrolled or newly enrolling providers and indirect owners with five percent or more ownership

in a high-risk provider, unless that provider and indirect owners has had a successful fingerprint-based background check completed within five years of the enrollment or revalidation date by centers for Medicare and Medicaid or another state Medicaid agency. The department requires a provider, or any person with a five percent or more direct or indirect ownership interest in the provider, to submit a set of fingerprints, within thirty days upon request from centers for Medicare and Medicaid or the medical services division. The provider and owners are required to cover the cost associated with obtaining the fingerprint-based criminal background check. That includes the cost of obtaining the fingerprints and the cost of processing the background investigation. The department will inform high-risk providers of the form and manner for providing fingerprint-based criminal background check information.

2. The department shall evaluate criminal history against the reasons for revocation found in 42 C.F.R. 424.535(a)(3) and based on offenses described in North Dakota Century Code chapter 12.1-16, homicide; 12.1-17, assaults - threats - coercion - harassment; 12.1-18, kidnapping; 12.1-27.2, sexual performances by children; or 12.1-41, Uniform Act on Prevention of and Remedies for Human Trafficking; in North Dakota Century Code section 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of a child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors; 12.1-20-06, sexual abuse of wards; 12.1-20-06.1, sexual exploitation by therapist; 12.1-20-07, sexual assault; 12.1-22-01, robbery; 12.1-22-02, burglary, if a class B felony under subdivision b of subsection 2 of that section; 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; 12.1-31-05, child procurement; 12.1-31-07, endangering a vulnerable adult; 12.1-31-07.1, exploitation of a vulnerable adult; subsection 1 of section 26.1-02.1-02.1 of North Dakota Century Code, fraudulent insurance acts; or an offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the enumerated North Dakota statutes.

3. The results of the fingerprint-based criminal background checks is confidential and may be reviewed by the medical services division only to determine if the provider or their owners are fit to participate in Medicaid or children's health insurance program. Results from the fingerprint-based criminal background checks must be reviewed by the medical services division to determine if the provider is allowed enrollment or continued enrollment. A provider, or any person with five percent or greater direct or indirect ownership interest in the provider, who is required by the medical services division or centers for Medicare and Medicaid services to submit a set of fingerprints and fails to do so may have its application denied or enrollment terminated.

History: Effective April 1, 2018.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-29-02
Law Implemented: NDCC 50-24.1-01

75-02-05-12. Application fee.

The department shall assess an application fee for all institutional providers who have not been assessed an application fee by centers for Medicare and Medicaid services or another state Medicaid agency. The amount of the application fee is determined by centers for Medicare and Medicaid services and is specific to a calendar year.

History: Effective April 1, 2018.
General Authority: NDCC 50-06-01.9, 50-24.1-04, 50-29-02
Law Implemented: NDCC 50-24.1-01