

Hospital Services

Purpose

ND Medicaid covers inpatient and outpatient services provided by hospitals that are certified to participate in the Medicare program, licensed and enrolled with ND Medicaid.

Applicability

Eligible Providers

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled with ND Medicaid on the date of service. Servicing providers acting as a locum tenens provider must be enrolled with ND Medicaid and be listed on the claim form. Please refer to [provider enrollment](#) for additional details on enrollment eligibility and supporting documentation requirements.

Hospital services can be provided by a facility that is licensed as a hospital and has completed and met all requirements on the [Hospital Group Application](#).

Eligible Members

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the [ND Medicaid MMIS Portal](#) or through the through the Automated Voice Response System by dialing 1.877.328.7098.

Refer to the [Member Eligibility Manual](#) for additional information regarding eligibility including information regarding limited coverage categories.

Covered Services and Limits

General Provider Policies

The [General Provider Policies](#) details basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled in ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

The [Procedure Code Look-up Tool](#) can be used to identify if a procedure code is covered by ND Medicaid along with code specific details such as ORP requirements, Service Authorization requirements, and current rates.

Covered hospital services are subject to the following guidelines:

- Ambulance services must be billed on a professional claim.
- Readmission to inpatient care on same day as discharge must be combined as one inpatient stay except when readmission is unrelated to original inpatient stay diagnosis and treatments.
- Outpatient services provided on the day of discharge may not be separately billed and must be included on the inpatient claim.
- Separate payments will be made for the mother and the newborn. The newborn and mother's charges must be billed on separate claims for each member.
- Charges should reflect the usual and customary charge of the hospital. Only the patient's due amount is subject to payment by Medicaid.
- Miscellaneous codes need a description and supporting documentation.

Service Authorization Requirements

Service authorizations (SA) are service specific. Please refer to the service specific policy or the [Look-Up Tool](#) to identify if a SA is required. SA forms can be found [online](#) and contain directions for proper submission. For Durable Medical Equipment service authorizations, please refer to the [DME Service Authorization Instructions – MMIS Web Portal](#).

ND Medicaid considers timely, retroactive, revision, or extension SA requests if all required forms and supporting information are submitted. Incomplete submissions will be returned or denied.

Documentation for service authorizations must:

- Be complete and accurate;
- Include relevant information to support the SA. Highlighting documentation that specifically supports the SA's medical necessity will expedite the review process;
- Match requested service date(s) on all forms and documents;
- Contain order/referral dates related to the SA requested dates;
- Include medical documentation, including medical records, to support medical necessity; and

- Include any other documentation required by ND Medicaid as listed in the service authorization criteria.

Requests not meeting these criteria may be returned, denied, or rejected as incomplete. Providers may include letters or narrative with their request for service authorization; however, information supplied in a letter or narrative does not supplant the need for documentation supporting medical necessity in the medical record.

Non-Covered Services

General Non-Covered Services

The [Noncovered Services Policy](#) contains a general list of services that are not covered by North Dakota Medicaid.

The following items are noncovered services and must be identified as noncovered if billed on an institutional claim:

- Admission kits
- Ambulance charges
- Barber/beauty
- Biofeedback
- Books/tapes
- Guest tray
- Late discharge
- Leave of absence room
- Lifeline
- Linen
- Non-patient room rent
- Nursing – outpatient
- Patient convenience items
- Postage
- Private room
- Social services
- Take home drugs
- Take home supplies
- Tax
- Technical support charges
- Telemetry in ICU
- TV/telephone/radio

Documentation Requirements

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the [Provider Requirements Policy](#).

Reimbursement Methodology and Claim Instructions

Timely Filing

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The [Timely Filing Policy](#) contains additional information.

Third-Party Liability

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The [Third Party Liability Policy](#) contains additional information.

Client Share (Recipient Liability)

Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The [Client Share Policy](#) contains additional information.

Reimbursement

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

ND Medicaid does not reimburse revenue codes 510-519 for hospital-based clinic services. Claims for dual eligibles (Medicare and Medicaid) should be billed as follows:

- If the member has Part A Medicare, charges for an inpatient stay must be billed entirely on an institutional claim.

- If the member has only Medicare Part B and incurs charges during an inpatient stay, the Part B charges must first be submitted to Medicare. After Medicare processes, the charges should be submitted to ND Medicaid on an institutional claim and include all charges for the inpatient stay. The institutional claim must include the Medicare Part B payment amount.
- If the member receives Medicare Part B services on an outpatient basis, the charges must first be submitted to Medicare. After Medicare processes, the charges should be submitted to ND Medicaid and must be billed on an institutional claim.

Effective Jan. 1, 2023, North Dakota Medicaid will require a valid HCPCS code for Revenue Code 0250 on all outpatient services. An NDC must also be submitted if the HCPCS code requires it.

In-State Prospective Payment System Hospitals

Inpatient Services

Payment to in-state acute prospective payment system (PPS) hospitals is based on All Patient Refined – Diagnosis Related Groups (APR-DRG) version 39 for inpatient services. The APR-DRG system classifies patients into clinically consistent groups with similar length-of-stay (LOS) patterns and utilization of hospital resources.

Claims for services that will be reimbursed using APR-DRG cannot be submitted until the patient is discharged or transferred.

APR-DRG claims are paid based on the DRG relative weight, times the hospital-specific rate. A capital payment will be included for all discharges. Capital payments may not be paid to a transferring hospital. A cost outlier may be paid in addition to the base payment if the calculated cost based on covered charges exceeds the APR-DRG threshold.

- Cost Outlier for APR-DRGs 580-640 (Newborns and Other Neonates)
Covered charges *hospital IP CCR – (57,000 or 1.5 * DRG)* .80 = cost outlier
- Cost Outlier for all APR DRGs except 580-640
Covered charges *hospital IP CCR – (60,000 or 2 * DRG)* .60 = cost outlier

3-Day Payment Window

When a member is admitted to a short-term acute care hospital, the hospital must review, up to three days prior to the inpatient admission, to see if any related outpatient services, diagnostic and non-diagnostic, were provided to the member by the hospital

and/or facility that is owned/operated by the hospital. If there were related outpatient services in the 3-day window, they are not covered as separate services and must be included on the inpatient claim along with other related services.

Long-Acting Reversible Contraceptive (LARC) Device

Effective for discharges October 1, 2024, a LARC device will be reimbursed outside of a DRG payment to the in-state PPS hospital when the device is inserted prior to the discharge from the delivery stay.

Billing Instructions:

- The hospital must bill the LARC device on an Outpatient claim with type of bill 0131;
- Report revenue code 0636 with one of the following J codes and the appropriate NDC:
 - J7296
 - J7297
 - J7298
 - J7300
 - J7301
 - J7307
- The date of service on the claim will be the date the device was placed;
- Payment for the device will be based on the fee schedule;
- The facility charges related to the insertion of the device are part of the DRG payment; and
- Do not include the charges for the LARC device that is billed on the Outpatient claim on the Inpatient claim.

Outpatient Services

The Enhanced Ambulatory Payment Grouping system (EAPG) applies to PPS hospital outpatient departments. EAPGs are assigned to each line based on submitted claims information, including patient characteristics, ICD-10 codes, and CPT®/HCPCS codes. The EAPG assignment for a given line may be affected by coding on other lines of service for the same claim. Packaging, consolidation, and discounting may be applied

based on other services provided during the same visit. A visit is all related services provided to one patient in one service encounter; a claim may comprise multiple visits. All outpatient services or visits occurring on the same day for a member must be billed on one claim.

ND Medicaid does not reimburse revenue codes 510-519 for hospital-based clinic services. EAPG claim lines are paid based on the EAPG relative weight times the hospital-specific rate times any applicable discounting factors. ND Medicaid does not reimburse lines with Modifier JW appended to EAPG claims.

In-State Critical Access Hospitals

Inpatient Services

Payment for inpatient services provided by in-state critical access hospitals (CAH) is made on a per diem rate.

- Claims must be submitted each calendar month on a separate claim form;
- Room and board (Revenue Codes 0100-0219) will be reimbursed on a per diem basis. The number of units billed for room and board Revenue Codes should include the date of discharge or death; and
- Revenue Codes 0300-0319, with appropriate HCPCS codes, will be reimbursed based on the lab fee schedule.

Outpatient Services

Payment for outpatient services provided by a CAH is made on a percentage of charges.

ND Medicaid does not recognize Method II billing for a CAH.

- Emergency room services should be billed as outpatient services on a separate claim form;
- Observation days and inpatient days cannot overlap;
- Physician services should be billed on a professional claim; and
- Revenue Codes 0300-0319, with appropriate HCPCS codes, will be reimbursed based on the lab fee schedule.

Out-of-State Hospitals

An out-of-state hospital is defined as one located in the United States and is located more than fifty (50) miles from the nearest North Dakota border.

Payment to out-of-state hospitals is based on a percentage of charges for both inpatient and outpatient services.

Out-of-state services require prior approval from ND Medicaid.

- Claims must be submitted each calendar month on a separate claim form. All claims for a patient stay must be submitted at the same time;

- The number of units billed for room and board (Revenue Codes 0100-0219) should include the date of discharge or death; and
- Revenue Codes 0300-0319, with appropriate HCPCS codes, will be reimbursed based on the lab fee schedule.

Rehabilitation Facilities

Payment for inpatient services provided by a rehabilitation facility is made on a per diem basis. Payment for outpatient rehabilitation services is made on a percentage of charges. Inpatient rehabilitation stays are subject to a limit of 30 days per stay at a distinct rehabilitation unit for patients 21 years of age and older.

- Claims must be submitted on a separate claim form each calendar month. All claims for a patient stay must be submitted at the same time; and
- The number of units billed for room and board (Revenue Codes 0100-0219) should include the date of discharge or death.

Long-Term Care Hospitals

Payment for services provided by a long-term care hospital (LTCH) is made based on a percentage of charges.

LTCH services require prior approval from ND Medicaid.

- Claims must be submitted on a separate claim form each calendar month. All claims for a patient stay must be submitted at the same time; and
- The number of units billed for room and board (Revenue Codes 0100-0219) should include the date of discharge or death.

Psychiatric Hospitals

Payment for inpatient services provided by a psychiatric hospital is made on a per diem basis.

ND Medicaid will cover inpatient psychiatric services for members under 21 years of age if the member meets certificate of need criteria.

- Claims must be submitted each calendar month on a separate claim form. All claims for a patient stay must be submitted at the same time; and
- The number of units billed for room and board (Revenue Codes 0100-0219) should include the date of discharge or death.

Inpatient psychiatric services, in a free-standing psychiatric hospital of more than 16 beds, are noncovered for members ages 21 through 64.

Kidney Dialysis Services

Effective for dates of service on or after March 1, 2021, HCPCS code A4657 – Syringe, with or without needle, will not be paid separately and considered incidental to the dialysis service performed on that day.

Kidney dialysis claims must be submitted to ND Medicaid using the following Revenue Codes when billing for:

- Revenue Code 0634 – Erythropoietin (OPE) < 10,000 units
- Revenue Code 0771 – Vaccine Administration
- Revenue Code 0821 – Hemodialysis Composite or Other Rate
- Revenue Code 0831 – Peritonea/Composite or Other Rate
- Revenue Code 0841 – CAPD/Composite or Other Rate
- Revenue Code 0851 – CCPD/Composite or Other Rate

References

- [North Dakota Administrative Code](#)
- [North Dakota Century Code](#)
- [Code of Federal Regulations](#)

Contact

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Policy Updates

April 2026

- In-State PPS Hospitals
 - Added language that transferring hospitals will not receive capital payments
- Out-of-State Hospitals
 - Added language about 50 miles from ND Borders
- Outpatient Services
 - Added language regarding JW modifier
- Eligible Providers

- Added language regarding hospital and Provider Enrollment requirements
- Service Authorization
 - Added language regarding SA requirements