

## Out-of-State Services

### PURPOSE

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Out-of-state services are care or services rendered by a provider that is located more than 50 miles outside of North Dakota. An out-of-state provider may be an individual or a facility but may not be located outside the United States.

### APPLICABILITY

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#### ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled on the date of service with ND Medicaid. Servicing providers acting as a locum tenens provider must enroll 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.

When approved, out-of-state services can be provided by enrolled providers that are 50 miles or more outside of North Dakota.

#### 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.

For members who are eligible for ND Medicaid Expansion, reach out to BlueCross/BlueShield of ND when requesting out-of-state care. 1.833.777.5779.

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

### COVERED SERVICES AND LIMITS

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#### 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.

Out-of-state services provided to a member must be covered ND Medicaid services and rendered by a provider enrolled with ND Medicaid. In addition, out-of-state providers may receive payment for services rendered only under the following circumstances:

- The service has received service authorization from ND Medicaid; or
- The health service is provided in response to an emergency while a member is out of the state; or
- The health service is provided to a Non-Title IV-E child for whom North Dakota makes a state foster care payment or adoption assistance payment.

## **OUT-OF-STATE MEDICAL CARE**

Out-of-state medical services require prior approval by ND Medicaid when done more than 50 miles of the North Dakota border. The member's North Dakota primary care provider and/or North Dakota specialty provider must submit a written request to ND Medicaid for authorization of each out-of-state service at least two weeks before scheduling an appointment.

Requests must include a Request for Service Authorization of Out-of-State Services ([SFN 769](#)), indicating:

- Member's name, date of birth and Medicaid number;
- Diagnosis;
- Reason for out-of-state care;
- Date of requested service, if known;
- Service(s) being requested;
- The in-state primary care provider and/or specialist; and
- The out-of-state practitioner and/or the facility being referred to.

Also include:

- Current (within three months) medical information supporting the need for out-of-state services;

- A written second opinion from an appropriate in-state board certified specialist that supports the need for out-of-state services; and
- Assurance that the service is not available in North Dakota.

Upon receipt of the above information, ND Medicaid will determine if the request for out-of-state services meets requirements and will approve or deny the request in writing, which will be sent to the requesting in-state provider(s), member, out-of-state provider(s), and human service zone office. The human service zone office is responsible for assisting members with travel, lodging, and meal arrangements, when requested through the Customer Support Center.

### **CHILDREN RECEIVING ADOPTION AND FOSTER CARE ASSISTANCE**

Children residing out-of-state and receiving a state-funded adoption subsidy (Non-IV-E) may be eligible for Medicaid until the age of 18 and possibly to the age of 21 (if the resident state offers Medicaid to youth over the age of 18). The child may be eligible to receive Medicaid in their state of residence through the provisions of the Interstate Compact on Adoption and Medical Assistance (ICAMA).

When moving out of state, the adoptive parent must notify the human service zone office administering their subsidy payment.

- If the state of residence has facilitated joinder in the Interstate Compact and gives reciprocity to other member states, the child will qualify for Medicaid in the state of residence. The state of residence is then notified of the child's eligibility for Medicaid through the ICAMA notification process. This is done through the Children and Family Services Division of the Department of Health and Human Services.
- If the state of residence has NOT facilitated joinder in the Interstate Compact and does NOT give reciprocity to other member states, the child will NOT qualify for Medicaid in the state of residence. In these situations, the child may continue to receive Medicaid through North Dakota.

Many out-of-state providers are not enrolled with ND Medicaid and it is the responsibility of the adoptive parents to approach out-of-state providers about enrolling with ND Medicaid. Services provided to children with a state-funded subsidy that are not covered by ND Medicaid, may be funded through the state-funded adoption subsidy program. Children in out-of-state placements with federal Title IV-E adoption subsidies or foster care payments are eligible for Medicaid in the state in which they reside. This includes temporary foster care placements.

Out-of-state providers that want to be reimbursed for covered services provided to children in foster care must enroll with ND Medicaid. Payment for services not covered by ND Medicaid may be the responsibility of a public agency and/or family.

### **OUT-OF-STATE EMERGENCY SERVICES**

Emergency out-of-state services are allowable at the in-state physician's discretion but are subject to ND Medicaid review. The transferring facility must notify ND Medicaid within 48 hours of transfer. Documentation must include:

- A completed Request for Service Authorization for Out-of-State Services ([SFN 769](#));
- Date of transfer;
- Mode of transportation; and
- Medical documentation, including the discharge summary.

The in-state facility must provide medical evidence for the need for air ambulance whenever it is used.

When a member receives emergent medical or surgical care when traveling outside of North Dakota, the out-of-state facility must submit the admission history and physical and discharge summary to ND Medicaid for review to determine the medical necessity of the service.

### **URGENT OR EMERGENCY SERVICES FOR MEMBERS TEMPORARILY OUT OF THE STATE**

In certain circumstances, ND Medicaid may cover urgent or emergency services for a member who is temporarily traveling outside of North Dakota. The out-of-state provider must enroll as a ND Medicaid provider and must submit supportive medical reports. Refer to the Out-of-State Provider section in the [Provider Enrollment](#) policy.

ND Medicaid does not cover any services received outside of the United States.

### **OUT-OF-STATE SERVICES FOR MEMBERS WITH A TRAUMATIC BRAIN INJURY (TBI)**

Out-of-state services in a specialized facility/program for a member with a traumatic brain injury requires service authorization. Requirements include:

- A letter of medical necessity from the attending physician;
- Complete documentation of clinical history;
- Treatment and test results;

- A listing of past placements and placement date; and
- Information regarding attempt to place in state.

The clinical information furnished by the referral source will be reviewed to determine if out-of-state placement is appropriate and medically necessary. If approval is granted, ND Medicaid will send an approval notice.

If the out-of-state facility is a Minnesota nursing facility specializing in services for members with a TBI, an out-of-state referral or approval is not required. However, the admitting Minnesota nursing facility must obtain a level of care determination from ND Medicaid's current contractor. Information regarding level of care procedures and screening forms are available in the [Nursing Facilities](#) policy.

### **OUT-OF-STATE PSYCHIATRIC SERVICES FOR CHILDREN UNDER 21**

Out-of-state psychiatric services for children under 21 require prior approval by ND Medicaid. A North Dakota agency requesting out-of-state psychiatric services for a child under 21 must ensure that appropriate in-state services are unavailable. The referring agency must be able to substantiate that:

- Treatment options within North Dakota have been provided with little to no improvement in the child's behavioral disorder (e.g., outpatient, acute inpatient, or residential treatment centers);
- The child has been denied admission to all available North Dakota facilities; or
- The out-of-state program is unique so that similar services are not available in North Dakota.

After ND Medicaid approval and prior to the child's admission, the out-of-state facility must complete an admission review with the ND Medicaid contractor to assure the child's cares and conditions meet North Dakota's Certificate of Need (CON) criteria. Additional information and CON forms are available in the manuals for psychiatric services for children under 21 located in the [Psychiatric Residential Treatment Facilities](#) policy.

### **TELEHEALTH**

Telehealth services provided to members while they are located in the State of North Dakota by ND Medicaid-enrolled out-of-state telehealth providers are not considered out-of-state care. The requirement to request authorization for out-of-state services does not apply in these situations. If the service itself requires service authorization the provider is still required to obtain authorization prior to rendering the service.

## **NON-COVERED SERVICES**

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### **GENERAL NON-COVERED SERVICES**

The Noncovered Services Policy contains a general list of services that are not covered by North Dakota Medicaid.

- Services that are available in North Dakota; and
- Out-of-country care is not allowed.

## **DOCUMENTATION REQUIREMENTS**

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### **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.

The out-of-state service authorization request must include current medical documentation that supports the need for out-of-state services. If the specialty service is available in North Dakota, the documentation needs to include why the requested service cannot be done in North Dakota.

## **REIMBURSEMENT METHODOLOGY AND CLAIM INSTRUCTIONS**

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### **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.

Each out-of-state service/visit requires an out-of-state service authorization. Services that have been approved will be listed on the service authorization letter.

## **CLAIM FORM**

Professional claims must be billed using the CMS 1500 claim form or the HIPAA compliant 837p format.

Institutional claims must be billed using the UB04 claim form or the HIPAA compliant 837i format. Detailed claim instructions are available on the ND Medicaid Provider Guidelines, Policies & Manual [webpage](#).

## **DEFINITIONS**

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*Out-of-State Care* – care that is provided 50 miles or more from the North Dakota border. It does not include out-of-country care.

## **REFERENCES**

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

## **FREQUENTLY ASKED QUESTIONS**

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**Q:** How can I find out the status of an out-of-state service authorization?

**A:** Contact the Medical Services Customer Support Center (701) 328-1000 or 866-614-6005. When applicable, the MMIS web portal can be used to check the status of the service authorization.

## CONTACT

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Medical Services  
600 East Boulevard Ave  
Bismarck, ND 58505-0250  
Phone: (701) 328-2310  
Email: [dhsmedicalservices@nd.gov](mailto:dhsmedicalservices@nd.gov)

## POLICY UPDATES

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### January 2025

Section	Updates
Requesting Out-of-State Services	Clarification added about requesting services through the Customer Support Center.

### January 2026

Section	Updates
	Format updated and clarifications made throughout.