

Swing Bed Facilities

Purpose

ND Medicaid covers medically necessary services provided by swing bed facilities 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.

Swing bed facility services can be provided by a facility that is licensed as a hospital in North Dakota and has completed and met all requirements of the [Swing Bed 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.

Level of Care Criteria

Members must meet nursing facility level of care criteria A, B, C, or D to be eligible for nursing facility services:

Level of Care A

An individual must meet one (1) of the criteria below to demonstrate a nursing facility level of care is medically necessary under level of care A: Nursing Facility level of care single criteria (meeting one satisfies medically necessary standard):

- The individual's nursing facility stay is, or is anticipated to be, temporary for receipt of Medicare part A benefits. A nursing facility stay may be based on this criterion for no more than fourteen days after termination of Medicare part A benefits.

- The individual is in a comatose state.
- The individual requires the use of a ventilator at least six hours per day, seven days a week.
- The individual has respiratory problems that require regular treatment, observation, or monitoring that may only be provided by or under the direction of a registered nurse or, in the case of a facility which has secured a waiver of the requirements of [42 CFR 483.35\(f\)](#), a licensed practical nurse, and is incapable of self-care.
- The individual requires constant help sixty percent or more of the time with at least two activities of daily living of toileting, eating, transferring, and locomotion. For purposes of this subdivision, constant help is required if the individual requires a caregiver's continual presence or help without which the activity would not be completed.
- The individual requires aspiration for maintenance of a clear airway.
- The individual has dementia, physician-diagnosed or supported with corroborative evidence, for at least six months, and as a direct result of that dementia, the individual's condition has deteriorated to the point when a structured, professionally staffed environment is needed to monitor, evaluate, and accommodate the individual's changing needs.

Level of Care B

If none of the criteria from level of care A are met, an individual must meet two (2) of the criteria below to demonstrate a nursing facility level of care is medically necessary under level of care B:

- The individual requires administration of prescribed:
 - Injectable medication;
 - Intravenous medication or solutions on a daily basis; or
 - Routine oral medications, eye drops, or ointments on a daily basis.
- The individual has one or more unstable medical conditions requiring specific and individual services on a regular and continuing basis that can only be provided by or under the direction of a registered nurse or, in the case of a facility

which has secured a waiver of the requirements of 42 CFR 483.35(f)), a licensed practical nurse.

- The individual is determined to have restorative potential and can benefit from restorative nursing or therapy treatments, such as gait training or bowel and bladder training, which are provided at least five days per week.
- The individual requires administration of feedings by nasogastric tube, gastrostomy, jejunostomy, or parenteral route.
- The individual requires care of decubitus ulcers, stasis ulcers, or other widespread skin disorders.
- The individual requires constant help sixty percent or more of the time with any one of the activities of daily living of toileting, eating, transferring, or locomotion. For purposes of this subdivision, constant help is required if the individual requires a caregiver's continual presence or help without which the activity would not be completed.

Level of Care C

If none of the criteria from level of care A or B are met, an individual with physical disabilities may show that a nursing facility level of care is medically necessary if the individual is determined to have restorative potential.

Level of Care D

If none of the criteria from level of care A, B, or C are met, an individual may demonstrate a nursing level of care is medically necessary if:

- The individual has an acquired brain injury, including anoxia, cerebral vascular accident, brain tumor, infection, or traumatic brain injury; and
- As a result of the brain injury, the individual requires direct supervision at least four hours a day, five days a week.

Preadmission Screening and Resident Review (PASRR) is not required for admission to a Swing Bed facility.

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.

Swing Bed Facility Services

Medically necessary swing bed facility services are covered for ND Medicaid members with a nursing facility level of care that are determined eligible for long term care services.

Routine Services

The daily rate established for swing bed facilities is an all-inclusive rate for routine services. Routine services include room and board, supplies, therapies, nursing supplies, equipment, transportation, and non-legend drugs. Separate claims for these items will be denied. Only the room and board charges should be submitted on the claim, do not enter ancillary charges.

Ancillary Services

Ancillary services are separately covered and reimbursed in addition to routine services. Ancillary services include radiology services, laboratory services, and prescription drugs. Ancillary services must be billed by the provider furnishing the service.

Service Authorization Requirements

No service authorization required.

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.

In addition to general non-covered services, certain services are not covered for Swing Bed Facilities.

Leave Days

Leave days are noncovered days. Leave day status is determined at midnight. Payment is not available for any period that a member does not actually occupy a bed.

Leave Days

ND Medicaid cannot make separate payment for swing bed facility services to the swing bed provider for a member who is receiving hospice care. The hospice provider is paid a daily rate and is responsible for paying the swing bed services provided to the

member. Once a member has elected hospice benefits, the swing bed provider may not submit a claim to ND Medicaid for swing bed facility services while the member is on hospice.

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.

The swing bed rate is the average rate paid to all ND nursing facilities for routine services furnished during the previous calendar year as required by [42 CFR §447.280\(a\)\(1\)](#).

Claim Form

Swing bed facility services must be billed using the UB 04 claim form or 837i. Detailed claim instructions available [ND Medicaid Provider Guidelines, Policies & Manual webpage](#).

Claim Requirements

Billing Timeframe

A swing bed facility must submit a claim for each month a member is in the facility, even if another payment source has paid for services. Payment by another payment source is used in the calculation of client share (recipient liability) towards other claims. Providers must not bill more than one calendar month per claim. The number of billed units must include the date of discharge or death.

Revenue Codes

Swing bed claims must be submitted using the following Revenue Codes:

Revenue Code 0110 - In-House Medicaid Days (private)

Revenue Code 0120 - In-House Medicaid Days (semiprivate)

Revenue Code 0160 - Medicare Full Benefit Period Days

Revenue Code 0169 - Medicare Coinsurance Days

Revenue Code 0183 - Leave Days

References

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

Related Policies

- [Nursing Facilities](#)
- [Basic Care Facilities](#)

Frequently Asked Questions

Question (Q): How long will ND Medicaid pay for Swing Bed services?

Answer (A): ND Medicaid will continue to pay for Swing Bed services as long as the person needs that level of care.

Q: Does ND Medicaid follow Medicare's requirement that a three consecutive calendar day inpatient hospital stay is required prior to moving to a swing bed?

A: No.

Contact

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Policy Updates

May 2025

- Format Changes and clarifying language added throughout the document.

October 2025

- Reimbursement Methodology
 - Updates made to Third Party Liability

April 2026

- ADA compliance updates made throughout the document.