

Home Health Services

Purpose

ND Medicaid covers services provided by home health agencies certified to participate in the Medicare program and 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.

Home health services are skilled nursing services, as defined in the [North Dakota Nurse Practice Act](#) (N.D.C.C. § 43-12.1), that are provided on a part-time or intermittent basis. All services are provided based on a licensed physician's orders and a written plan of care. Other services include home health aide services, physical therapy, occupational therapy, speech pathology, audiology services, medical supplies, equipment, and appliances suitable for use in the home and telemonitoring.

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.

To qualify for coverage of any home health services, a member must meet the criteria listed below:

- The member must require skilled nursing care on a part-time or intermittent basis, (at least one skilled nursing service every 60 days), or physical therapy or speech therapy or occupational therapy to qualify for home health services;
- A physician, nurse practitioner, clinical nurse specialist, or physician assistant must certify that the member requires skilled nursing care in the home. Services must be medically necessary and considered the most appropriate setting consistent with meeting the member's medical needs; and

- Services must be provided at the member's place of residence, or other setting, as prior authorized.

A face-to-face encounter for the initial ordering of home health services must occur no more than 90 days before or 30 days after the start of home health services. A face-to-face encounter:

- Must be related to the primary reason the member requires home health services;
- Must be performed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant; and
- May be performed via telehealth or in-person. Telephone encounters are insufficient.

Clinical findings of the encounter must be communicated by the rendering provider to the ordering provider. This communication must be documented in the medical record along with medical necessity for the home health services.

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.

Home health agencies must provide the following services:

- Skilled nursing by a registered nurse or licensed practical nurse under the supervision of a registered nurse;
- Home health services aid under the direction of a registered nurse; and

- Physical, occupational, and speech therapy services provided by licensed therapists.

Limits

Home health agency visits are limited to 50 visits per member per calendar year. These visits are not subject to prior approval and do not apply to extended-hour visits.

Extended hour visit requests must be prior authorized by ND Medicaid.

Service Authorization Requirements

A service authorization is required when it is medically necessary for the member to exceed the home health visit limitation. If the same level of care or a more intense level of care (i.e. more skilled nurse visits or the addition of another service) is necessary beyond the 50 visits, the home health agency must submit a service authorization. If Medicare is primary and covers Home Health Services a prior authorization is not required.

ND Medicaid contracts with Acentra to complete home health service authorizations. Acentra uses a nationally recognized clinical support tool with evidence-based criteria, to determine if a member meets a certain level of care or services based on the member's needs, to determine the medical necessity for the type of service(s) requested and the number of home health visits or extended home health units (e.g., InterQual). Please note that hours approved may be less than or equal to what the physician has ordered and is based upon clinical documentation supplied and the evidence-based criteria.

Home health authorization requests are reviewed using the Home Health Support Tool. Extended home health authorization requests are reviewed using the Private Duty Nursing support tool.

Service authorization requests for additional visits beyond the 50 visits must be submitted prior to the last visit of the 50-day limitation and prior to additional services being provided. All requests for authorization of additional visits must be submitted with the following information:

- [The Home Health/Extended Home Health Request for Service Authorization \(SFN 15\)](#);
- A legible copy of the current [Home Health Certification and Plan of Treatment Form](#) (CMS 485) or certified plan of treatment with the most recent 60-day summary or a copy of the original physician's order; and
- Any pertinent documentation to substantiate the need for additional visits.

Authorizations 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.

Each service authorization is valid for 60 days. Subsequent requests after the first 60-day period must be medically necessary, have a service authorization, and be received by ND Medicaid prior to the service being provided or before the next 60-day period. If the service authorization is not received prior to the 60-day time period, the visits will be denied.

The home health agency must keep copies of all documents submitted to ND Medicaid. Approved service authorizations are dependent on the member's eligibility during the approved service authorization period. If a member requires additional services in an approved period, the home health agency is responsible for submitting a service authorization for the additional services.

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.

Noncovered Home Health services include:

- Individual procedures such as:
 - Eye drops or ointment instillations;
 - Routine glucose monitoring and insulin administration;
 - Routine foot care;
 - Stasis ulcer maintenance care;
 - Pediatric maintenance care;
 - Routine medication setup; or
 - Other services that become self-care activities after the member or family members or others have been taught how to do the procedure(s) in a reasonable amount of time.
- Personal care services not directly related to the condition requiring skilled nursing care such as:
 - Light housekeeping;
 - Transportation;
 - Meal preparation;

- Laundry;
- Shopping;
- Childcare; or
- Respite care.
- Respiratory therapy services (as a separate category of services). A registered nurse may provide respiratory therapy as a nursing service;
- Observation and assessment by a skilled nurse are not reasonable and necessary to the treatment of the illness or injury when indications are that it is a long-standing pattern of the member's condition, and no clinical progress is demonstrated; and
- Telephonic services.

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](#).

Electronic Visit Verification (EVV)

Federal law requires states to verify when home health care services are provided in the home or community. Effective July 1, 2023, Medicaid-enrolled providers must use an approved electronic visit verification (EVV) system.

[EVV system](#) documentation requirements include:

- Service type;
- Individual receiving the service;
- Date of service;
- Location of service;
- Individual providing the services; and
- Begin and end time of service.

If a provider does not have an EVV, their EVV does not meet the state's standard criteria, or the EVV is not connected to the state EVV aggregator, the provider may use the State's third party EVV system. Claims for services submitted without EVV information will be rejected by ND Medicaid. Please refer to the [EVV policy](#) for more information.

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.

Payment to Home Health Agencies for covered Home Health services provided to Medicaid patients is made per encounter. The term "encounter" is defined as a face-to-face visit between the patient and one or more home health professionals during which services are rendered. An encounter for each type of service is defined as:

- Skilled Nursing Visit – An encounter is a continuous period of time not to exceed a four-hour period in which the nurse remains at the residence of a member for the purpose of providing ongoing skilled nursing services.
- Home Health Aide Visit – An encounter is a continuous period of time not to exceed a four-hour period in which the aide remains at the residence of the member for the purpose of providing necessary ongoing home health aide services.
- Therapy Services – All therapy services will be reimbursed per encounter.

Encounters with more than one home health professional and multiple encounters with the same home health professionals on the same day and at a single location constitute a single visit for each discipline.

ND Medicaid covers the following services:

- G0156 – Home Health Aide
- G0151 – Physical Therapy
- G0159 – Physical Therapy Maintenance
- G0157 – Physical Therapy PTA
- G0152 – Occupational Therapy
- G0160 – Occupational Therapy Maintenance Program
- G0158 – Occupational Therapy OTA
- G0153 – Speech Therapy
- G0161 – Speech Therapy Maintenance Program
- G0300 – Skilled Nursing (LPN)
- G0299 – Skilled Nursing (RN)

Please refer to the [Home Health Agency Fee Schedule](#) for rates.

Home Health Telemonitoring will be covered within the same limits as other home health services. Home Health Telemonitoring is not allowed for the initial Home Health evaluation visit or for the discharge visit. In addition, Home Health Telemonitoring is limited to no more than forty percent (40%) of the total visits during each certification period.

Claim Form

Home Health Services must be billed using the CMS UB04 claim form or 837i. Detailed claim instructions are available on the [ND Medicaid Provider Guidelines, Policies & Manual webpage](#).

References

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

Contact

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Policy Updates

April 2026

- Service Authorizations
 - Added information about Medicare Members.
- Added additional clarifications and updates throughout the policy.