NURSING FACILITIES

PURPOSE

ND Medicaid covers services provided by nursing facilities (NF) that are certified to participate in the Medicare program, licensed, and enrolled with North Dakota (ND) Medicaid.

APPLICABILITY

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 in ND Medicaid and be listed on the claim form. Out of state providers may enroll with ND Medicaid. “Out of state provider” means a provider who is located more than fifty (50) miles from a North Dakota border within the United States. Please refer to provider enrollment for additional details on enrollment eligibility and supporting documentation requirements.

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.

Eligible members must qualify for a Long-Term Care Medicaid coverage. They must:

- Be 65 years or older **or;**
  - Blind **or;**
  - Have a disability determined by the Social Security Administration **or;**
  - Medically frail.
- Have a medical need for long term care services. In general, this means a person must be unable to care for themselves without outside help.
- Have less than $3,000 for a single person or $6,000 for a couple in their checking and savings accounts, certificate of deposits, etc.

When applying for long-term care Medicaid coverage, members may use the long-term care application checklist to see what documents should be included with an application.

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 of the 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.

PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

Preadmission Screening and Resident Review (PASRR) is a federal requirement defined in 42 CFR 483 Subpart C to prevent inappropriate admission and retention of individuals with serious mental illness (SMI) and/or intellectual and developmental disabilities (ID/DD) in nursing facilities. PASRR requires:

- Evaluation of all individuals who apply or reside in Medicaid certified nursing facilities for serious mental illness (SMI) and/or intellectual and developmental disabilities (ID/DD);
- Individual choice to be served in the most appropriate setting for their needs;
- Provision of specialized services for an individual with SMI or ID/DD who resides in a nursing facility.

North Dakota's PASRR consists of a two-part screening process:

1. **Level I**: Identification of individuals who are suspected of having SMI or ID/DD. Level I screenings include written notice to the individual or resident and his or her legal representative that the individual or resident is suspected of having SMI or ID/DD and is being referred to the state mental health or intellectual disability authority for Level II screening.
2. **Level II**: Evaluation and determination of need for nursing facility services and specialized services. Level II screenings assess the individual's needs meet a level of care required in a nursing facility setting and whether the individual has special behavioral health treatment needs.

A third-party assessor provides PASRR for all applicants to a Medicaid-certified NF, performs all Level I screenings to identify whether an individual has evidence of ID/DD/RC or SMI, and performs all SMI Level II reviews and refers ID/DD/RC Level II reviews to the appropriate DD Program Administrator. For additional information related to the third-party assessor for North Dakota PASRR please visit: Tools and Resources | Maximus

The Level I portion is applicable only to nursing facility applicants/residents (swing beds are exempt) and occurs:

- Prior to admission to a Medicaid certified nursing facility (regardless of the applicant's type of payment)
- For residents of Medicaid certified NFs experiencing changes in status that suggests the need for a first- time or updated PASRR Level II evaluation (referred to as a "status change")
- Prior to the conclusion of an assigned time limited stay for individuals with SMI, ID, and/or RC whose stay is expected to exceed time-limited provisions.

Level I screens do not apply to the following individuals:

- Re-admitted NF residents following medical hospital treatment. If there was a significant change in status for an individual with MI, ID, and/or RC, Maximus must be contacted following the individual's readmission.
- Individuals with MI, ID, and/or RC transferring from one facility to another, (although transfers of residents with MI, ID, and/or RC must be reported to Maximus through Pathtracker in AssessmentPro)

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.

LEAVE DAYS

The hospital leave policy ensures that a bed is available when a resident returns to the nursing facility. ND Medicaid will cover a maximum of 15 days per occurrence for hospital leave. A nursing facility may not bill for hospital leave days if it is known that the resident will not return to the facility.

Once the nursing facility accepts payment for hospital leave on behalf of a Medicaid resident, then the nursing facility must still bill ND Medicaid for hospital leave days beyond the 15th day that the resident's bed was held. Any days exceeding the 15-day limit are noncovered days.

ND Medicaid will cover a maximum of 30 therapeutic leave days per resident per rate year. The rate year begins January 1st for in-state long term care (LTC) nursing facilities.

Once the nursing facility accepts payment for therapeutic leave on behalf of a Medicaid resident, then the nursing facility must still bill ND Medicaid for therapeutic leave days beyond the 30th day that the resident's bed was held. Any days exceeding the 30-day limit are noncovered days.

Hospital and therapeutic leave days, occurring immediately following a period when a resident received Medicare Part A benefits in the facility, are noncovered days.

The day of death is paid for in all instances except when a resident is in a Medicare benefit period, in which case the day of death is a noncovered day. The day of a resident's discharge to any location is a noncovered day.

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.

NURSING FACILITY NON-COVERED SERVICES

The following services are not included in the nursing facility's per diem payment. The services may be separately billed to North Dakota Medicaid by the provider furnishing the service:

- Prescription drugs, except vaccines;
- Physician services for direct resident care;
- Laboratory and radiology services performed outside of facility;
- Mental health services;
- Dental services;
- Prosthetic devices and prosthetic supplies provided for an individual resident which are prescribed by a doctor; and

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 sources 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.

IN-STATE NURSING FACILITIES

Nursing facility rates are set annually using allowable historical operating costs, reported by facilities on an annual cost report, and adjustment factors as explained in N.D. Admin. Code § 75-02-06. The rate established for in-state nursing facilities is an all-inclusive rate for routine services. Routine services include supplies, therapies, nursing facility supplies, equipment, nonemergency transportation, and non-legend drugs. Separate billings for these items will not be paid.

OUT OF STATE NURSING FACILITIES

The rate for out of state nursing facilities is based on the rate established by the Medicaid agency in the state where the facility is located. Included routine services are

determined by the rate established by that state's Medicaid agency, such as; supplies, therapies, nursing facility supplies, equipment, nonemergency transportation, and non-legend drugs. Ancillary charges not included in the out of state nursing facility rate must be billed by the provider furnishing the service.

CLAIM FORM

Nursing facility services must be billed using the UB 04 claim form or 837i.

CLAIM REQUIREMENTS

A resident on hospital or therapeutic leave on the last day of the month whose bed is being held by the facility is "Still a Patient".

The number of billed units must include the date of discharge or death.

A separate claim line must be submitted beginning with the start date of a new Minimum Data Set (MDS) classification period whether or not the classification changed.

Claims must be submitted using the following Revenue Codes when billing for:

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 **0182**	Medicare Noncovered Leave Days
Revenue Code **0183**	Therapeutic Leave Days
Revenue Code **0185**	Hospital Leave Days

A facility must submit a claim for every month a member is in the facility, even if insurance has paid for the services. This allows the system to apply recipient liability towards other claims. The claim should be submitted immediately after the month is over. Do not bill more than one calendar month per claim.

ND Medicaid cannot make payment for nursing facility services to the nursing facility provider if a resident has elected hospice care. The hospice is paid the rate applicable to the resident and is responsible for paying the nursing facility for services provided to the resident. Recipient liability, if any, is applied to the hospice provider's claim. Once a resident has elected hospice benefits, the LTC nursing facility provider may not submit a claim for services provided while the resident is on hospice.

A hospice provider must submit a revocation of election form to ND Medicaid before payment can be made to a nursing facility for a resident who no longer is receiving hospice benefits. The facility should contact the hospice provider to ensure that a revocation notice has been filed with ND Medicaid prior to billing for nursing facility services.

DEFINITIONS

Claim – A bill for one or more services for one beneficiary

Cost report – The department approved form for reporting costs, statistical data, and other relevant information of the facility

Facility – A nursing facility not owned or administered by state government or a nursing facility, owned or administered by state government, which agrees to accept a rate established under this chapter. It does not mean an intermediate care facility for individuals with intellectual disabilities

Hospital leave day – Any day that a resident is not in the facility, but is in an acute care setting as an inpatient or has been identified in a resident assessment instrument as 'discharged-return anticipated'

Provider – The organization or individual who has executed a provider agreement with the department

Resident – An individual who has been admitted to the facility, but not discharged

Therapeutic leave day – any day that a resident is not in the facility, another nursing facility, swing-bed facility, transitional care unit, subacute unit, an intermediate care facility for individuals with intellectual disabilities, or an acute care setting, or, if not in an institutional setting, is not receiving home and community based waivered services

REFERENCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations

RELATED POLICIES

Swing Bed Facilities
Basic Care Facilities

CONTACT

Medical Services
600 East Boulevard Ave
Bismarck, ND 58505-0250
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Email: dhsmedicalservices@nd.gov

POLICY UPDATES

April 2025

Section	Summary
	Format changes and clarifying language added throughout.