

Basic Care Services

Purpose

ND Medicaid covers services provided by instate licensed and enrolled basic care facilities.

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.

Basic Care Facility services can be provided by a basic care provider licensed under [North Dakota Century Code chapter 23-09.3](#), [North Dakota Administrative Code chapter 33-03-24.1](#), and [North Dakota Administrative Code chapter 33-03-24.2](#).

To enroll as a Basic Care Facility provider, the facility must be licensed as a Basic Care Facility and enroll with taxonomy code 311Z00000X (Basic Care). Providers should utilize the [Basic Care Facility 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.

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

- Be a resident of North Dakota
- Be age 65 years or older, or
- Be at least 18 years or older and determined to be disabled or blind, or
- Have a disability determined by the Social Security Administration; and
- The individual must:
 - Not be severely impaired in any of the following Activities of Daily Living (ADLs):
 - Toileting;

- Transferring to or from a bed or chair;
- Eating, or;
- Meet one of the following conditions:
 - Impaired in three (3) out of the following four Instrumental Activities of Daily Living (iADL):
 - Meal Preparation
 - Housekeeping
 - Medication Management
 - Laundry, or;
 - Has a health, welfare, or safety needs, including a need for supervision or a structured environment, and;
- Have less than \$3,000 in countable assets like savings and checking accounts, stocks, bonds or other types of assets for a single person or less than \$6,000 for a couple.

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.

To receive assistance through the Basic Care Assistance Program (BCAP) or the Medicare State Plan (MSP) a member must have a case manager. This can be obtained by:

- Calling or submitting a request through the [Aging and Disability Resource Link \(ADRL\)](#);
- Submitting a [Basic Care application](#) – OR – a completed [Medicaid Application for the Elderly and Disabled](#) (SFN 958) to the eligibility unit; or
- Emailing agingbcferrals@nd.gov. This is typically initiated by the basic care facility staff as they have someone on spend down. The Basic Care Case Manager would then submit a [Transmittal Between Units form](#) (SFN 21) to notify the eligibility unit of the referral.

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.

The North Dakota Basic Care program provides room and board along with health, social, and personal care for residents of a Basic Care facility to attain or maintain the residents' highest level of functioning.

Leave Days

ND Medicaid covers medical care and therapeutic leave days for Medicaid members expected to return to the facility to ensure bed availability for a member upon their return.

Medical Care Leave

ND Medicaid covers a maximum of 30 days per occurrence for medical care leave. Medical care leave includes any day that a resident is not in the facility but is in a licensed health care facility, including a hospital, swing bed, nursing facility, or transitional care unit, and is expected to return to the facility. A basic care facility may not bill for medical care leave days if it is known that the resident will not return to the facility. A basic care facility may not bill for personal care services days while a resident is out of the facility utilizing medical care leave.

For example, if a resident is on leave for medical care from 1/1/2026 to 1/10/2026, the basic care facility must use Revenue Code 0185 Medical Leave Days for room and board reimbursement. A basic care facility cannot bill Revenue Code 0167 Personal Care Services Days while the resident is on medical care leave. If a provider submits a claim with the Revenue Code 0167 while the resident is utilizing medical care leave days, the billing claim will be denied. On 1/11/2026, if the resident has returned to the

basic care facility, the basic care facility can resume normal billing for In-House Medicaid Days for Room & Board and Personal Care Service Days.

The following revenue codes cannot be billed if the resident is out of the basic care facility on medical care leave:

- Revenue Code 0110 – In-House Medicaid Days for Room & Board (private)
- Revenue Code 0120 – In-House Medicaid Days for Room & Board (semiprivate)
- Revenue Code 0167 – Personal Care Services Days

Once the basic care facility accepts payment for medical care leave on behalf of a Medicaid resident, the basic care facility must bill ND Medicaid for all medical care leave days used by or held for the resident including days in excess of 30 days. Any days exceeding the 30-day limit are noncovered by ND Medicaid and are the member's responsibility. The day of a resident's discharge to any location is a noncovered day.

Therapeutic Leave

ND Medicaid covers a maximum of 28 therapeutic leave days per resident per rate year (July 1 – June 30).

Once the basic care facility accepts payment for therapeutic leave on behalf of a Medicaid resident, the basic care facility must bill ND Medicaid for all therapeutic leave days used by or held for the resident including days in excess of 28. Any days exceeding the 28-day limit are noncovered days and are the member's responsibility. The day of a resident's discharge to any location is a noncovered day. A basic care facility may not bill for personal care service days while the resident is utilizing therapeutic leave days.

For example, if a resident is out of the basic care facility from 1/1/2026 to 1/10/2026, a basic care facility must use Revenue Code 0183 Therapeutic Leave Days for Room & Board for days out of the facility. A basic care facility may not bill Revenue Code 0167 Personal Care Services Days while the resident is out of the basic care facility for therapeutic leave days. If a basic care facility submits a claim for Revenue Code 0167 while Medicaid resident is away from the basic care facility using therapeutic leave days, the billing claim will be denied. On 1/11/2026, if the resident has returned to the basic care facility, the basic care facility will resume normal billing for In-House Medicaid Days for Room & Board and Personal Care Service Days.

On the last day of the month, a resident on medical or therapeutic leave whose bed is being held by the facility is “Still a Patient”.

The following revenue codes cannot be billed if the resident is out of the basic care facility on therapeutic leave:

- Revenue Code 0110 - In-House Medicaid Days for Room & Board (private)
- Revenue Code 0120 - In-House Medicaid Days for Room & Board (semiprivate)
- Revenue Code 0167 - Personal Care Services Days

Service Authorization Requirements

Personal care services and room and board services require a Basic Care Personal Care Service Plan (Service Plan) be completed by the member’s case manager. The service plan will assess the services needed and based on the Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) score, will authorize the services necessary. The Service Plan must be sent by the case manager to the authorized facility personnel via the departments electronic case management system.

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 services are not included in the basic care facility’s payment. These services may be separately billed to North Dakota Medicaid by the provider furnishing the service:

- Prescription drugs;
- Over the counter (OTC) medication;
- Physician services for direct resident care;
- Laboratory and radiology services performed outside of facility;
- Mental health services;
- Dental services; and
- Durable medical equipment.

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.

Basic Care 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 § 75-02-07.1](#)

Claim Form

Basic care services must be billed using the UB 04 claim form or 837i. Detailed claim instructions are available online at [ND Medicaid Provider Guidelines, Policies & Manual](#).

Claim Requirements

Basic care facility services must have separate lines for personal care and room and board on one claim using the following Revenue Codes when billing for:

- Revenue Code 0110 – In-House Medicaid Days for Room & Board (private)
- Revenue Code 0120 – In-House Medicaid Days for Room & Board (semiprivate)
- Revenue Code 0183 – Therapeutic Leave Days for Room & Board
- Revenue Code 0185 – Medical Leave Days for Room & Board
- Revenue Code 0167 – Personal Care Services 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.

If the member is on Hospice and residing in a Basic Care Facility, the Basic Care must submit the claim for both room and board and personal care services. The Hospice provider will bill for the Hospice Nursing Services.

The day of a resident's death is a covered day. The number of billed units must include the date of discharge or death. The day of a resident's discharge to any location is a noncovered day.

Definitions

Applicable definitions found in [N.D. Admin. Code § 75-02-07.1-01](#).

References

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

Contact

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Policy Updates

April 2025

- Format updates and clarifications added throughout the document.

August 2025

- Non-Covered services
 - Added information about OTCs

April 2026

- ADA updates made throughout the document.