Basic Care Facilities

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 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.

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 to enroll.

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 65 years or older **or**
- Blind **or**;
- Have a disability determined by the Social Security Administration;
- Need assistance as identified by a functional assessment for Activities of Daily Living (ADLs) such as bathing, dressing, eating, toileting;

- Have health, welfare, or safety needs, including a need for supervision or a structured environment, which requires care in a licensed adult family foster care home or a licensed basic care facility or;
- Is impaired in three of the following four instrumental activities of daily living:
    - Preparing meals;
    - Doing housework;
    - Taking medicine; and
    - Doing laundry; and
- 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.

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;
- Emailing agingbcreferrals@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 start and SFN 21 to notify the eligibility unit of the referral.

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.

COVERED SERVICES

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. Medicaid 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.

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.

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".

SERVICE AUTHORIZATION REQUIREMENTS

Personal care services and room and board services require a SFN 662 be completed by the member's case manager. The service authorization 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.

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. The services may be separately billed to North Dakota Medicaid by the provider furnishing the service:

- Prescription drugs;
- Physician services for direct resident care;
- Laboratory and radiology services performed outside of facility;
- Mental health services;
- Dental services;
- 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.

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.

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

Section	Summary
	Format updates and clarifications added throughout policy.