



BASIC CARE FACILITIES

This document is subject to change. Please check our web site for updates.

This provider manual outlines policy and claims submission guidelines for claims submitted to the North Dakota Health Enterprise MMIS.

This document covers services provided by basic care facilities that are licensed and enrolled with North Dakota (ND) Medicaid.

AUTHORIZATION OF SERVICES

ND Medicaid will not cover personal care services unless an Authorization to Provide Personal Care Services form (**SFN 663**) is completed by the individual's case manager. The completed form must be submitted to ND Medicaid.

The Department will not cover room and board services unless a Personal Care Plan (**SFN 662**) is completed by the individual's case manager. The completed form must be submitted to the Department.

LIMITS ON LEAVE DAYS

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

Once the basic care facility accepts reimbursement for medical leave on behalf of a Medicaid resident, then the basic care facility must still bill ND Medicaid for medical leave days beyond the 15th day that the resident's bed was held but they are non-covered days.

ND Medicaid will cover a maximum of 28 therapeutic leave days per resident per rate year. The rate year begins July 1st.

Once the basic care facility accepts reimbursement for therapeutic leave on behalf of a Medicaid resident, then the basic care facility must still bill ND Medicaid for therapeutic

leave days beyond the 28th day the resident's bed was held but they are non-covered days.

The day of death for a resident is a covered day. The day of discharge for a resident is a non-covered day.

BILLING GUIDELINES

Basic care facilities must bill for services using the North Dakota Web Portal using the electronic claims submission web pages or Electronic Data Exchange transaction. The claim must include a valid National Provider Identification number (NPI) and taxonomy code.

Claims must be submitted to ND Medicaid using the applicable *Bill Type 211-218*.

The bill type frequency must coincide with the status code billed. Claims must be submitted using the following status codes:

- 01** Discharged to Home or Self-Care
- 02** Discharged/Transferred to a Short-Term General Hospital
- 04** Discharged/Transferred to a Facility that Provides Custodial or Supportive Care
- 20** Expired
- 30** Still a Patient
- 40** Expired at Home
- 41** Expired in a Medical Facility
- 42** Expired – Place Unknown
- 50** Hospice - Home
- 51** Hospice – Medical Facility Providing Hospice Level of Care
- 61** Discharged/Transferred to a Hospital-Based Medicare Approved Swing Bed
- 62** Discharged/Transferred to an Inpatient Rehabilitation Facility including Rehabilitation Distinct Part Units of a Hospital
- 63** Discharged/Transferred to a Medicare Certified Long Term Care Hospital
- 65** Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
- 66** Discharged/Transferred to a Critical Access Hospital
- 70** Discharged/Transferred to another Type of Healthcare Institution

A resident on medical 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 units billed must include the date of discharge or death.

Basic care facility claims must be submitted electronically to ND Medicaid and charges must be broken down between personal care and room and board on separate lines on one claim using the following *Revenue Codes* when billing for:

Revenue Code 110	In-House Medicaid Days for Room & Board
Revenue Code 183	Therapeutic Leave Days for Room & Board
Revenue Code 185	Hospital Leave Days for Room & Board
Revenue Code 167	Personal Care Services Days

A facility must submit a claim for every month a Medicaid eligible resident is in the facility, even if insurance has paid for the charges. This allows the system to start applying 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.