# Short Term Custodial (STC) and Long Term Care (LTC) Payment Policy

## Applicability

This Policy applies to the following Fallon Health products:

☐ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☐ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO (Medicaid-only)
☒ Summit Eldercare PACE
☐ Fallon Health Weinberg PACE
☐ Community Care (Commercial/Exchange)

## Policy

Fallon Health covers Short Term Custodial (STC) and Long Term Care (LTC) services when medically necessary. Services must be ordered by a physician and supported by a written treatment plan. Authorization is required for STC and LTC admissions and for each change in level of care (LOC). Desired results of care must be clearly documented by a written treatment plan approved by a physician. Services are covered in accordance with the guidelines referenced at: Nursing Facility Manual for MassHealth Providers | Mass.gov.

Nursing facility services shall be no more restrictive than the State plan nursing facility benefit, including Medically necessary stays beyond one hundred eighty (180) days.

Additionally, providers must submit claims for all Fallon Health members residing in a Long Term Care facility and receiving NaviCare benefits, regardless of whether or not the member has PPA (Patient Paid Amount).

## Definitions

**Add-On Services:** Nursing Facility services as defined in 101 CMR 206.00 eligible for member specific additional reimbursement to the per-diem rates. Payable for NaviCare only.

**Long Term Care (LTC) Services**. As defined according to 130 CMR 456.000, services that a nursing facility provides to members who have chronic conditions that require assistance with daily living activities including dressing, bathing, eating, transfers and mobility\ambulation. These services are provided in a nursing facility because the member requires more intensive level of medical and personal care than what can be provided in a home setting.

**Medically Necessary/Medical Necessity.** As defined by the Executive Office of Health and Human Services (EOHHS), covered services that are consistent with benefits provided by Medicare and MassHealth, and that provide the member with coverage to at least the same extent, and with the cumulative effect, as provided by the combination of Medicare and MassHealth. Per Medicare, these services are deemed reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body Member, or otherwise medically necessary under 42 U.S.C. § 1395y. Per MassHealth, such services are provided in accordance with 130 CMR 450.204 and are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and for which there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service that is more conservative or less costly. Further, such provided services are of a quality that meets professionally recognized standards of health care and substantiated by records including evidence of such medical necessity and quality. In addition, a service is Medically Necessary when it may attain, maintain, regain, improve, extend, or expand the

member's health, function, functional capacity, overall capacity, or otherwise support the member's ability to do so; or a delay, inaction, or a reduction in amount, duration, or scope, or type or frequency of a service may jeopardize the member's health, life, function, functional capacity, or overall capacity to maintain or improve health or function.

**Minimum Data Set (MDS).** A Medicare-provided standardized assessment tool, mandated by federal law for use in nursing facilities to assess the key domains of function, health, and service use. MDS assessment forms include the MDS-HC (Minimum Data Set-Home Care) for home care and the MDS 3.0 for nursing facility residents.

**Non-Medical Leave of Absence (NMLOA).** A temporary absence from the nursing facility for non-medical reasons subject to the requirements in 130 CMR 456.430 through 130 CMR 456.432.

**Nursing Facility (NF).** An institution or a distinct part of an institution that meets provider eligibility and certification requirements of 130 CMR 456.404 or 130 CMR 456.405. Further, it provides services to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health related care services above the level of custodial care to other than individuals with intellectual disabilities.

**Patient-Paid Amount (PPA).** The portion of monthly income that a member in a nursing facility must contribute to the cost of care.

**Preadmission Screening and Preadmission Resident Review (PASRR):** Defined as a federal and state required process that identifies evidence of serious mental illness (SMI) and\or intellectual or developmental disabilities (ID\DD) in individuals who seek admission to Medicaid or Medicare certified nursing facilities, regardless of payment source. The process entails a preadmission screening (Level I) that may determine if the member has SMI and\or ID\DD, that may require additional level evaluation (Level II). Once the Level II evaluation is complete, the evaluator will determine nursing facility level of care and specialized services.

**Short Term Custodial (STC) Services**. Temporary, non-medical care that helps individuals with their daily, personal assistance activities. This distinguishes it from skilled care, which is medically necessary and requires licensed personnel.

## Reimbursement

The Plan will reimburse Short Term Custodial (STC) and Long Term Care (LTC) in accordance with 101 CMR 206.00 and MassHealth Nursing Facility Providers Billing and Claims Guidance found at: Nursing Facility Providers Billing and Claims Information | Mass.gov. Services must be authorized by Fallon Health to be eligible for reimbursement.

Fallon Health will reimburse a nursing facility for nonmedical leave of absences for up to a total of ten (10) days per twelve (12)-month period starting with the first day of the nonmedical leave, if all conditions in 130 CMR 456.430 through 130 CMR 456.433 are met and the member is a resident of the nursing facility. For the purpose of nonmedical leave of absence, a day is defined as a continuous 24-hour period. Absences that span less than 24 hours from the nursing facility do not constitute a day of absence.

For transportation services provided, please refer to the Skilled Nursing Facility Payment Policy.

## Referral/notification/prior authorization requirements

### Short Term Custodial (STC)

Nursing facility providers must work with Fallon Health's care team for hospital discharge planning as Fallon Health requires prior authorizations be secured prior to STC admissions.

The following documentation is required and must be submitted to support the STC admission:

- Status Change Form (SC-1) for members in a nursing facility
- Minimum Data Set (MDS) Assessment
- Nursing facility Care Plan and recent physician visit notes

- MassHealth LTC Services Application (SACA-2)

**Long Term Care (LTC)**

Upon admission or discharge and during status change events, nursing facilities must complete and submit required documentation to MassHealth and/or Fallon Health, as requested and as often as required by MassHealth's schedule. The MDS Assessment must be conducted or coordinated by a registered nurse with the appropriate participation of health professionals and must also be conducted in person with the member, include direct observation, and include communication with the Enrollee and direct care staff on all shifts.

Authorization is required for all LTC covered services. Initial authorizations will be approved for ninety (90) days. Additional authorization may be provided every ninety (90) days thereafter, upon completion of a Health Risk Assessment and Care Plan review.

## Billing/coding guidelines

Unless otherwise stated, Fallon Health follows industry standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

**Long Term Care (LTC)**

Claims must be submitted with a valid HIPPS (Health Insurance Prospective Payment System) code. The HIPPS code must match the HIPPS code provided by MassHealth and included in the approved authorization. Claims that do not meet this criteria may be denied.

Note: As HIPPS levels change at each review per MDS requirement at 5, 14, 30, 60 and 90 days, the facility must submit a new inpatient notification with each RUG/MDS review.

HIPPS codes must be reported under revenue code "0022" (HIPPS).

Room and board must be reported under revenue code 0100 (Room and Board).

Service units reported under revenue code "0022"(HIPPS) and revenue code "0100" (Room & Board) must equal each other.

There should only be one claim detail line for revenue code "0022" and revenue code "0100" on an inpatient claim.

Use revenue code 0185 to report medical leave days and revenue code 0183 to report non-medical leave days.

Service units reported under "0022" (HIPPS) must not include service units reported for "0183"(Non-Medical Leave) and "0185"(Medical Leave).

Fallon Health will not pay for nursing facility services rendered to a member during a period in which the nursing facility has failed to comply with the required Preadmission Screening and Preadmission Resident Review (PASRR) with respect to the member.

In addition, nursing facilities cannot bill the member for such services for any claims denied by Fallon Health due to billing errors.

**Patient Paid Amount (PPA) for STC and LTC**

The Patient Paid Amount (PPA) represents the portion of a nursing facility resident's monthly income that must be applied toward the cost of their care. When a member is admitted to a nursing facility, the PPA is deducted from Fallon's monthly capitation payment.

If applicable, the PPA must be clearly indicated on the claim using Value Code FC (recurring monthly income), with the corresponding dollar amount entered in the adjacent field. Please use the first Value Code field to report the PPA. During claims processing, Fallon Health will subtract the reported PPA from the total payment issued to the nursing facility.

**Add On Services and Payments**

Fallon Health pays reimburses the following add-on services according to applicable MassHealth regulations. Please note that these apply to NaviCare only.

| HCPCS Code | Description |
|---|---|
| S0310 | Bariatric Add-on |
| S0311 | Homeless Add-on |
| S0315 | Enhanced Temporary Resident Add-on |
| S0316 | Temporary Resident Add-on |
| S0317 | Medicaid Transitional Add-on |
| S0320 | Substance Use Disorder (SUD) Induction Add-on |
| S0340 | Behavioral Indicator Add-on |
| S0341 | Substance Use Disorder (SUD) Add-on |
| S0342 | Tracheostomy Add-on |

## Place of service

This policy applies to services rendered in the inpatient setting.

## Policy history

Origination date: 01/01/26

Connection date & details: October 2025 – Policy origination.

*The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.*