Assisted Living Payment Policy

Policy Statement

This policy documents Neighborhood Health Plan of Rhode Island's (Neighborhood's) coverage and reimbursement requirements for Assisted Living services provided by participating and nonparticipating providers. These services maximize continued independence for members that live in a residential community care facility by providing supervision, security, and safety through personalized assistance with activities of daily living.

Scope

This policy applies to:
☐**Medicaid** *excluding Extended Family Planning (EFP)*
☒**INTEGRITY**
☐**Commercial**

Prerequisites

All services must be medically necessary to qualify for reimbursement. Neighborhood may use the following criteria to determine medical necessity:

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Industry accepted criteria such as Interqual
- Rhode Island Executive Office of Health and Human Services (EOHHS) recommendations
- Clinical Medical Policies (CMP)

It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Clinical Medical Policies.

Please contact Provider Services at 1-800-963-1001 for questions related to this policy.

Coverage and Reimbursement

Neighborhood reimburses Assisted Living services on a per diem basis. Rates are inclusive of all services as specified by the provider contract.

Activities of Daily Living (ADLs) are defined as:

- **Bathing**: Direct care or constant supervision and cueing during the entire activity of a shower, bath, or sponge bath for the purpose of maintaining adequate hygiene.

- **Dressing**: Direct care of constant supervision and cueing during the entire activity of dressing and undressing, and taking prostheses, braces, anti-embolism garments, or assisted devices on or off.
- **Eating**: Direct care or constant supervision and cueing, or physical assistance provided by staff for a portion of or entirety of meals to consume food or drink through the mouth using routine or adapted utensils, inclusive of the ability to cut, chew, and swallow food
- **Mobility**: Assistance provided to the member when he/she must be steadied, assisted, or guided in ambulation, or is unable to self-propel a wheelchair.
- **Toileting**: Assistance provided to the member due to incontinence of bladder or bowels or scheduled or routine assistance catheter or colostomy care, and includes assistance transferring on/off the toilet, self-cleansing, and changing of pads/briefs.
- **Transferring**: Assisting or lifting the member to another position between surfaces, such as from bed to chair or wheelchair, walker, or standing position. This also includes changes of position in a wheel chair for pressure relief or positions in bed, as well as transfer to bed during the day secondary to poor sitting tolerance.

Assisted Living includes the following levels of care[1]:

- **Tier A**:
  - Daily assistance with at least two (2) ADLs **AND**
  - At least one (1) hour of personal care

- **Tier B**:
  - Extensive assistance with a minimum of two (2) ADL's OR
  - Seven (7) or more hours per week of any combination of:
    - Personal care
    - Limited health care services
    - Care coordination, including behavioral health or memory care (cognitive decline) or complex medication managment

- **Tier C:**
  - Extensive assistance with a minimum of three (3) ADLs AND
  - Sixteen (16) hours or more per week of any combination of:
    - Personal care
    - Limited health care services
    - Care coordination, including behavioral health or memory care (cognitive decline) or complex medication managment

Coverage Exclusions

The following services are excluded from the Assisted Living benefit:

- Facility room and board
- Assisted living services for a member enrolled in an Adult Day Health program

[1] EOHHS Assisted Living Certification Standards 01.07.22

- Other services that are similar or duplicative in nature

Claim Submission

Claims may be billed with a date span, subject to the following:

- Services were provided consecutively on each date within the span
- Any break in service within a date span must be indicated on a new claim line
- Dates of service must be within the same month

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Adjustments, corrections, and reconsiderations must include the required forms. All submissions must be in compliance with National Claims Standards.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Documentation Requirements

To qualify for reimbursement, all records must be kept in accordance with state and federal regulations.

A treatment record must be created for each member receiving Assisted Living services, and contain no less than the following:

- Member identification (Neighborhood ID, name);
- Physician's order supporting need for skilled services;
- Member diagnosis;
- Initial admission assessment;
- Individual service plan (ISP) written by a registered nurse or certified assisted living administrator. Plan must be written within seven (7) days after move-in, and include:
    - Services and interventions needed (may include services from outside agencies);
    - Description of frequency and duration of services/interventions;
    - Identification of party responsible for providing services/interventions;
    - Date and signature of registered nurse responsible for plan development, and/or certified assisted living administrator.
- ISP nurse review, as required by state regulations;
- Documentation of regular member assessment, not to exceed 12 months, or as change in member condition requires;
- Documentation of ISP review, not to exceed 12 months;
- Re-admission assessment, as required by state regulations, if applicable.

Once a record is established, additions, deletions, modifications, or edits of any kind must be made

in compliance with Chapter 3 of the CMS Medicare Program Integrity Manual.

Electronic Medical Records (EHRs) are compliant with CMS and Neighborhood's documentation standards. All EHRs must meet state and federal privacy guidelines.

Whether electronic, paper, or a combination of both, all records must be accurate, legible, and completed with signature in a prompt manner, but no later than 30 days from the date of service. At its discretion, Neighborhood may request copies of patient records at any time to ensure adherence to state, federal, and reimbursement requirements as outlined in this document.

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

Member Responsibility

Integrity members have a monthly patient share provision, as determined by the Rhode Island Executive Office of Health and Human Services (RI EOHHS)

Patient share applies on the first date of service and is deducted from the benefit allowed amount at the time of payment adjudication.

Coding

The inclusion of a code in this policy does not guarantee coverage or reimbursement.

CPT Code	Description
T2031	Assisted living, Tier A Facility; Beneficiary A or B Member
T2031-UB	Assisted living, Tier B Facility; Tier B Member
T2031-UC	Assisted living, Tier C Facility, Tier C Member

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to

update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Document History

Date	Action
3/16/2022	Format Changes. Update to include RI Assisted Living Rate Reform Tier A and Tier B language and coding effective 11/1/21.Update to include RI Assisted Living Rate Reform Tier C language and coding effective 2/1/22.
3/1/2018	Policy Created and Effective