Short-Term Custodial and Long-Term Care Clinical Coverage Criteria

Description

Service Description

Short-Term Custodial (STC) and Long-Term Care (LTC) are non-skilled nursing facility services for eligible NaviCare members who meet nursing facility level-of-care requirements and cannot be safely and adequately supported in a less restrictive setting at the time of review. STC is temporary custodial care with a documented reassessment and discharge or transition plan. LTC is ongoing custodial nursing facility care when the need for institutional care is expected to continue.

These criteria do not apply to Medicare-covered skilled nursing or skilled rehabilitation services. Skilled levels of care are reviewed under applicable Medicare requirements and Fallon Health Skilled Nursing Facility Clinical Coverage Criteria.

Policy

This Policy applies to the following Fallon Health products:

☐ Fallon Medicare Plus

☐ MassHealth ACO

☒ NaviCare HMO SNP

☐ PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)

☐ Community Care

Prior authorization is required for STC before the first date of service for which payment is sought. Effective December 1, 2026, initial and annual prior authorization are required for LTC, with additional authorization when the member changes level of care or transfers to another nursing facility, unless otherwise directed by Fallon Health or applicable law.

Fallon Health Clinical Coverage Criteria

Fallon Health Clinical Coverage Criteria apply to Navicare members only.

General Medical Necessity Requirements

Fallon Health considers STC or LTC medically necessary when all applicable benefit requirements are met and the clinical record supports all of the following:

1. The member meets applicable MassHealth nursing facility level-of-care requirements.
2. The member has medical, functional, cognitive, behavioral health, environmental, or support needs that cannot be safely and adequately met in a less restrictive setting at the time of review.
3. The requested nursing facility service is appropriate to the member's individualized needs and is not duplicative of another covered service.
4. Available community-based services, informal supports, caregiver resources, housing arrangements, equipment, and environmental modifications have been considered. Any proposed community alternative must be available, appropriate, sufficient, consistent with the member's preferences and person-centered care plan, and capable of safely meeting the assessed need.
5. The record includes current clinical and functional information sufficient to support the requested level and duration of care.
6. Applicable Preadmission Screening and Resident Review (PASRR) requirements are satisfied, including Level II review when required.

A request may not be denied, reduced, suspended, or terminated solely because a less costly alternative exists. Any adverse determination must be based on an individualized review and be consistent with applicable MassHealth requirements, the member's current needs, benefit terms, and applicable law.

Short-Term Custodial Criteria
STC is medically necessary when the General Medical Necessity Requirements are met and all of the following apply:

1. The member requires nursing facility level of care but does not require a Medicare-covered or other skilled nursing or skilled rehabilitation level of care.
2. The member cannot be safely supported in the community at that time.
3. The custodial need is time-limited and return to the community or transition to another appropriate setting or level of care is reasonably anticipated.
4. There is a documented discharge or transition plan identifying the anticipated destination, barriers to discharge, services or supports needed for community return, responsible parties, and a reassessment date.
5. Active discharge or transition planning continues throughout the STC stay.

STC is not a required step before LTC, is not automatically authorized for a fixed maximum period, and must not be used solely to delay an appropriate LTC determination.

Continued STC
Continued STC requires updated documentation demonstrating that nursing facility level of care continues to be met, the need remains temporary, the member still cannot be safely supported in the community, and active discharge or transition planning is continuing. A change from STC to LTC requires notification to and authorization by Fallon Health before LTC services are billed.

Long-Term Care Criteria
LTC is medically necessary when the General Medical Necessity Requirements are met and all of the following apply:

1. The member requires ongoing nursing facility level of care.
2. The need for custodial nursing facility care is expected to be ongoing rather than temporary.
3. Community-based services, informal supports, caregiver resources, housing arrangements, equipment, environmental modifications, and other available alternatives cannot safely and adequately meet the member's assessed needs.
4. Nursing facility placement is the least restrictive available setting capable of safely meeting the member's current needs.

A member may be admitted directly to LTC when these requirements are met. Prior STC placement is not required.

Authorization and Documentation Requirements

Initial STC Request
The request must include documentation necessary to establish clinical eligibility and the planned duration of the stay. Documentation may include:

- Physician or referring provider order or request and clinical documentation supporting nursing facility level of care.
- Current nursing facility care plan, relevant hospital or provider records, and recent clinical notes.
- PASRR documentation, including Level II information when required.
- Documentation of available alternatives to institutionalization and why they are inadequate to meet the member's current needs.
- The anticipated discharge destination, barriers to discharge, services or supports needed for community return, responsible parties, and a reassessment date.
- SC-1 and other MassHealth forms or eligibility documentation when applicable.

Continued STC Requests

- Continued STC authorization requests must include:
- current clinical and functional documentation supporting continued nursing facility level of care;
- an updated facility care plan;
- the member's progress toward established goals;
- documentation of community alternatives considered and why they remain insufficient; and
- an updated discharge or transition plan identifying the anticipated disposition, remaining barriers, actions being taken, required services and supports, responsible parties, and reassessment date.

Continued STC will not be authorized solely because the member remains in the facility or to delay an appropriate transition to LTC.

Initial and Continued LTC Review

An initial LTC prior authorization request is required for a new LTC admission, and an annual renewal request is required before the current authorization expires. A new request is also required when the member changes level of care or transfers to another nursing facility, and when otherwise required by Fallon Health or applicable MassHealth requirements.

Facilities must complete and submit required admission, discharge, assessment, and status-change documentation to EOHHS and Fallon Health in the required form and timeframe. The facility must provide current MDS information and other documentation requested to support continued eligibility, care management, payment integrity, audit, or institutional rating-category reconciliation. Routine contracted-provider LTC authorization requests do not require submission of a HIPPS code.

Medicare Variation

This policy addresses the MassHealth custodial nursing facility benefit for NaviCare members. Medicare-covered skilled nursing or skilled rehabilitation services are outside the scope of these criteria and must be reviewed under applicable Medicare requirements and Fallon Health Skilled Nursing Facility Clinical Coverage Criteria.

MassHealth Variation

Fallon Health follows applicable MassHealth nursing facility requirements when determining eligibility and medical necessity for STC and LTC services. In the absence of a service-specific MassHealth Medical Necessity Guideline, review is consistent with the MassHealth definition of medical necessity and applicable nursing facility regulations. These criteria are not intended to be more restrictive than MassHealth requirements.

Exclusions

STC or LTC is not medically necessary under this policy when any of the following apply:

- The member requires a skilled nursing or skilled rehabilitation level of care.
- The member does not meet applicable nursing facility level-of-care requirements.
- The member can be safely and adequately supported in a less restrictive setting using available and appropriate services and supports.
- For STC, the need is not temporary or there is no active discharge or transition plan.
- The requested service is solely for convenience, housing, or supervision unrelated to a covered medically necessary nursing facility need.
- The service duplicates another covered service or is not included in the member's benefit.

Coding

Short-Term Custodial (STC) and Long-Term Care (LTC) are authorization levels of care and are not represented by unique HCPCS procedure codes. Billing is based on applicable nursing facility revenue codes, HIPPS classification requirements, and authorized add-on services when eligible.

Revenue Codes

Code	Description
0022	HIPPS (Health Insurance Prospective Payment System) code. Required on LTC claims when applicable and must be supported by an accepted MDS assessment.
0100	Room and Board. Units must equal the units billed under Revenue Code 0022.
0183	Non-Medical Leave of Absence Days.
0185	Medical Leave of Absence Days.

Billing requirements: HIPPS codes must be reported under revenue code 0022, and room and board must be reported under revenue code 0100. Units reported under revenue codes 0022 and 0100 must equal each other. Medical leave days must be reported under revenue code 0185 and non-medical leave days under revenue code 0183. Units reported under revenue code 0022 must exclude units reported under revenue codes 0183 and 0185.

Leave-of-absence billing applies only when the applicable MassHealth requirements and limits are met. A medical leave of absence is an inpatient hospital or observation stay for a nursing facility resident. A non-medical leave of absence is a temporary absence for non-medical reasons; for purposes of the Fallon payment policy, a qualifying non-medical leave day is a continuous 24-hour period, and an absence of less than 24 hours is not a leave day.

HIPPS Codes

HIPPS code assigned through the accepted MDS assessment and EOHHS classification. The specific HIPPS code varies by resident assessment and acuity and is not a fixed code list within the policy.

NaviCare Nursing Facility Add-On HCPCS Codes

Code	Description
S0310	Bariatric Add-on
S0311	Homelessness Add-on
S0315	Enhanced Temporary Resident Add-on
S0316	Temporary Resident Add-on
S0317	Medicaid Transitional Add-on
S0320	Substance Use Disorder Induction Add-on
S0340	Behavioral Indicator Add-on
S0341	Substance Use Disorder Add-on
S0342	Tracheostomy Add-on
S0353	Home Dialysis in a Nursing Facility Setting (Medicaid Secondary Payer)
S0354	Home Dialysis in a Nursing Facility Setting (Medicaid Primary Payer)
94004	Ventilator Add-On
94004 U1	Communication-Limited Resident Ventilator Add-On

The listed add-on codes may be payable for eligible NaviCare nursing facility members only when all applicable MassHealth requirements, Fallon Health authorization requirements, provider agreement terms, and billing documentation requirements are met. Inclusion of a code in this table does not by itself establish coverage or payment.

Authorization Level of Care Codes

- Short-Term Custodial (temporary custodial nursing facility stay with discharge or transition plan)
- Long-Term Care (ongoing nursing facility residency meeting nursing facility level of care)

Authorization of STC or LTC establishes the approved level of care but does not guarantee payment. Claims remain subject to member eligibility, the authorized dates and level of care, accurate coding, accepted MDS/HIPPS support when applicable, MassHealth requirements, and the provider agreement.

Summary of Evidence

These criteria are based on applicable MassHealth administrative and billing regulations, nursing facility requirements, standard payments to nursing facilities, the MassHealth Nursing Facility Manual, and the approved Fallon Health Short-Term Custodial and Long-Term Care Payment Policy.

Analysis of Evidence (Rationale for Determination)

The criteria distinguish temporary non-skilled institutional care from ongoing custodial placement, require individualized nursing facility level-of-care review, preserve direct admission to LTC when appropriate, and require active discharge planning for STC. They also maintain separation from Medicare-covered skilled services and align clinical authorization requirements with Fallon Health's approved payment policy.

References

- 130 CMR 450.000, Administrative and Billing Regulations
- 130 CMR 456.000, Nursing Facility Services
- 130 CMR 456.425 through 456.433, Medical and Non-Medical Leaves of Absence
- 101 CMR 206.00, Standard Payments to Nursing Facilities
- MassHealth Nursing Facility Manual
- Fallon Health Short-Term Custodial and Long-Term Care Payment Policy, effective December 1, 2026
- Fallon Health Skilled Nursing Facility Payment Policy

References

Origination date:	12/1/2026
Review/Approval(s):	Technology Assessment Committee: 09/22/2026 (new policy). Utilization Management Committee: (new policy, approved).

Instructions for Use

Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Fallon Health generally follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

For plan members enrolled in NaviCare, Fallon Health first follows CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the

exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.