

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

Applicability

This Policy applies to the following Fallon Health products:

- ☐ Fallon Medicare Plus
- ☐ MassHealth ACO
- ☒ NaviCare HMO SNP
- ☐ Summit Eldercare PACE
- ☐ Fallon Health Weinberg PACE
- ☐ Community Care

Policy

This policy applies only to NaviCare HMO SNP members receiving Short-Term Custodial or Long-Term Care services in a nursing facility. For skilled nursing or skilled rehabilitation levels of care, refer to the ***Skilled Nursing Facility Payment Policy***.

Fallon Health covers medically necessary Short-Term Custodial (STC) and Long-Term Care (LTC) nursing facility services for NaviCare members in accordance with applicable MassHealth requirements, the NaviCare benefit, the member's individualized needs, and Fallon Health authorization requirements. This policy does not apply to Medicare-covered or other skilled nursing facility stays.

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.

STC is not a required step before LTC. STC is appropriate when the need for custodial nursing facility care is temporary and discharge to the community is reasonably anticipated. A member may be admitted directly to LTC when nursing facility level of care is met and the need for institutional care is expected to be ongoing.

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.

HIPPS Code. A Health Insurance Prospective Payment System code reported on an institutional claim and supported by the applicable MDS assessment and acceptance information.

Institutional Rating Tier. The EOHHS-assigned NaviCare rating category for an eligible member residing in an institutional long-term care setting. The applicable tier is tied to the member's accepted assessment and nursing classification information.

Long-Term Care (LTC). Nursing facility services for a member who meets nursing facility level-of-care requirements and whose need for institutional care is expected to be ongoing rather than temporary.

Minimum Data Set (MDS) 3.0. The standardized resident assessment used in nursing facilities. For NaviCare members residing in a nursing facility, the facility must complete and submit the MDS 3.0 to

EOHHS within 14 days of admission and at least annually thereafter and must comply with other applicable assessment and submission requirements.

Medically Necessary/Medical Necessity. Services that are clinically appropriate, consistent with Medicare and MassHealth requirements, and reasonably required to prevent, diagnose, treat, maintain, or improve a member's health, function, or functional capacity, or to prevent deterioration in the member's condition. Services must be supported by medical documentation and provided in accordance with professionally recognized standards of care.

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 a nursing facility resident's monthly income that must be applied toward the cost of care when applicable.

Preadmission Screening and Resident Review (PASRR). The federal- and state-required process for identifying serious mental illness and/or intellectual or developmental disability and determining whether additional evaluation or specialized services are required.

Short-Term Custodial (STC). Temporary, non-skilled nursing facility care for a member who does not require a skilled rehabilitation level of care, cannot be safely supported in the community at that time, and has a documented plan for reassessment and anticipated discharge to the community or transition to the appropriate ongoing level of care.

Reimbursement

Fallon Health reimburses authorized STC and LTC services subject to applicable MassHealth requirements, 101 CMR 206.00, 130 CMR 456.000, the provider agreement, applicable fee schedules, member eligibility, accurate billing, and supporting documentation.

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.

For transportation associated with a skilled nursing facility stay, refer to the Skilled Nursing Facility Payment Policy and the Transportation Services Payment Policy, as applicable.

Non-Medical Leave of Absence

Fallon Health may reimburse qualifying non-medical leave days for a NaviCare member residing in a nursing facility when the requirements and limits of 130 CMR 456.430 through 456.433 are met. A leave day is a continuous 24-hour period; an absence of less than 24 hours does not constitute a leave day.

Referral/notification/prior authorization requirements

Skilled Levels of Care

This policy does not govern skilled nursing or skilled rehabilitation admissions or continued stays. Providers must follow the **Skilled Nursing Facility Payment Policy** for skilled levels of care.

Short-Term Custodial (STC)

Prior authorization is required before the first date of STC service for which payment is sought, unless otherwise directed by Fallon Health or applicable law. The request must support that the member meets nursing facility level of care, does not require a skilled level of care, cannot be safely supported in the community at that time, and has a time-limited custodial need with a documented discharge or transition plan.

The STC request should include the documentation necessary to establish clinical eligibility and the

planned duration of the stay, which 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, and a reassessment date;
- SC-1 and other MassHealth forms or eligibility documentation when applicable.

STC is not automatically authorized for a fixed maximum period and must not be used solely to delay an appropriate LTC determination. Continued STC requires documentation that the need remains temporary and that active discharge or transition planning continues. A change from STC to LTC requires notification to and authorization by Fallon Health before billing LTC services.

Long-Term Care (LTC)

Effective December 1, 2026, contracted nursing facilities must submit an initial LTC prior authorization request for a new LTC admission and an annual renewal request before the current authorization expires. Routine LTC authorization requests do not require submission of a HIPPS code. A new authorization 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, and status-change documentation to EOHHS and Fallon Health, including the SC-1 and MDS 3.0, in the form and timeframe required. The MDS 3.0 must be completed and submitted to EOHHS within 14 days of admission and at least quarterly thereafter.

Facilities must provide Fallon Health with MDS information and other documentation requested for care management, payment integrity, audit, rating-category reconciliation, or continued eligibility review. Fallon Health may request an iQIES assessment history, EOHHS acceptance report, or equivalent evidence showing the accepted MDS assessment, acceptance date, and associated HIPPS code.

Billing/coding guidelines

Unless otherwise stated, providers must follow current industry-standard coding requirements, applicable MassHealth billing instructions, Fallon Health billing guidance, and their provider agreements. Authorization does not guarantee payment.

Long-Term Care HIPPS and Institutional Tier Requirements

Although a HIPPS code is not required on a routine contracted-provider LTC prior authorization request effective December 1, 2026, LTC claims must include the appropriate HIPPS code when required for billing. The billed HIPPS code must be supported by an MDS assessment accepted by EOHHS for the applicable billing period and must be consistent with the member's EOHHS-assigned institutional rating tier.

The facility is responsible for verifying that the MDS and HIPPS information submitted to EOHHS has been accepted and for retaining evidence of that acceptance. An MDS form containing a HIPPS code, without evidence of submission and acceptance, may not be sufficient to validate the billed code.

Upon request, the facility must provide an iQIES assessment history, EOHHS acceptance report, or equivalent documentation showing the accepted assessment date and HIPPS code. Claims may be pended, denied, adjusted, or recovered when the billed HIPPS code is unsupported, was not accepted for the billing period, is inconsistent with the applicable institutional tier, or otherwise fails applicable billing requirements. The member may not be balance billed for amounts denied or recovered due to provider billing or documentation errors.

HIPPS codes must be reported under revenue code 0022. 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.

Out-of-Network and Ad Hoc Arrangements

HIPPS codes and additional rate or clinical documentation may remain required for out-of-network or ad hoc LTC authorization requests when needed to establish the authorized service, negotiated rate, or payment terms.

Patient Paid Amount (PPA) for 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

Certain member-specific nursing facility add-on services may be reimbursable in addition to the applicable nursing facility per diem rate for NaviCare members when all applicable MassHealth requirements, Fallon Health authorization requirements, provider agreement terms, and billing requirements are satisfied. Add-on reimbursement is subject to member eligibility and compliance with the requirements established under 101 CMR 206.00 and applicable MassHealth Nursing Facility Rate Add-On Billing Guidance. Add-on services are not payable for medical or non-medical leave days unless otherwise required by MassHealth.

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
S0340	Behavioral Indicator Add-On
S0341	Substance Use Disorder (SUD) 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

Place of service

This policy applies to STC and LTC services rendered in an inpatient nursing facility setting.

References

130 CMR 450.000, Administrative and Billing Regulations
130 CMR 456.000, Nursing Facility Services

Policy history

Origination date:	01/01/2026
Connection date & details:	October 2025 – Policy origination October 2026 – Under Policy, clarified that STC is temporary and is not a prerequisite for LTC; clarified prior authorization requirements for STC and LTC; under Billing/coding guidelines, added that HIPPS codes must be supported by EOHHS-accepted MDS information and aligned with the institutional rating tier; Fallon Health may request iQIES or EOHHS acceptance evidence.

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.