Neighborhood Health Plan OF RHODE ISLAND™

# Coverage and Reimbursement Policy

## Assisted Living

### Policy Overview

This policy documents Neighborhood Health Plan of Rhode Island's (Neighborhood's) coverage and reimbursement requirements for Assisted Living services provided by participating and non-participating 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 Neighborhood's **UNITY** and **INTEGRITY** lines of business, for services provided within scope of licensure pursuant to R.I.G.L. §23-17.4.[i]

### Coverage

Neighborhood's benefit includes the following levels of care:

- Base Level assisted living;
- Enhanced level, non-skilled assisted living;
- Enhanced level , skilled assisted living;
- Dementia care assisted living.

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.
- *Personal Hygiene/Grooming:* Direct care or constant supervision and cueing during the entirety of combing hair, brushing teeth, shave, application of make-up, nail care, eyeglasses, and jewelry application.
- *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.

## Benefit Limitations

The benefit period for this service is determined according to medical necessity criteria and utilization review.

**INTEGRITY** is an integrated Medicare and Medicaid product, and affords coverage to the broadest extent allowed by federal and state regulations, whichever is greater.

## Benefit Exclusions

The following services are excluded from coverage:

- Facility room and board.
- Assisted Living services for members enrolled in an Adult Day Health program;
- Other services that are similar or duplicative in nature.

## Member Responsibility

**UNITY** and **INTEGRITY** plans 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.

## Medical Necessity Criteria

All services must be medically necessary to qualify for reimbursement.

Members must meet level of care requirements, as outlined below:

**Base Level Assisted Living:**

- Must require medication administration and/or oversight;
- Must require assistance with a minimum of two (2) activities of daily living;
- Must require six (6) or more hours of personal care a week.

**Enhanced Level Assisted Living:**

- Must require assistance with a minimum of two (2) activities of daily living;

- Must require between seven (7) and twelve (12) hours of any combination of personal care, limited health care services, care coordination (including behavioral health), and/or health and home stabilization services.

**Dementia Care Assisted Living:**

- Member must have a diagnosis of Alzheimer's disease or another related dementia, and be determined to need memory care.
- Must need assistance with a minimum of three (3) activities of daily living;
- Must require thirteen (13) hours or more of any combination of personal care, limited skilled nursing, and/or behavioral health or health and home stabilization services.

For questions regarding these criteria, please contact Utilization Management at (401) 459-6060.

## Prior Authorization

Prior authorization is required for all Assisted Living services. Please refer to Neighborhood's Medical Management Request Forms for details.

## Payment Methodology

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

## Claim Submission

Billable services are subject to contractual agreements and must meet timely filing requirements to be considered for reimbursement.

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.

Providers credentialed to provide base and enhanced level services must bill all services on a CMS-1450 (UB-04) claim form or via electronic X12 837I format.

Providers credentialed to provide base, enhanced, *and* dementia level services must bill all services on a CMS-1500 Professional claim form or via electronic X12 837P format.

Adjustments, corrections, and reconsiderations must include the required forms. All submissions must be in compliance with national claims standards.[ii]

## Coding

Neighborhood approved codes are listed below.

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.[iii]

| Revenue Code | HCPCS | Modifier | Description |
|---|---|---|---|
| 0100 | T2031 | N/A | Assisted Living, waiver; per diem, base level. |
| 0100 | T2031 | U1 | Assisted Living, waiver; per diem, enhanced non-skilled. |
| 0100 | T2031 | U1/U3 | Assisted Living, waiver; per diem, enhanced, skilled. |

| Place of Service | HCPCS | Modifier | Description |
|---|---|---|---|
| 13 | T2031 | U4 | Assisted Living, waiver; per diem, dementia care. |

## Record Keeping

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:

a) Member identification (Neighborhood ID, name);
b) Physician's order supporting need for skilled services;
c) Member diagnosis;
d) Initial admission assessment;
e) 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.
f) ISP nurse review, as required by state regulations;
g) Documentation of regular member assessment, not to exceed 12 months, or as change in member condition requires;
h) Documentation of ISP review, not to exceed 12 months;
i) 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.[iv]

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.[v]

## Disclaimer

**This guideline is informational only, and not a guarantee of reimbursement.**

Claim payments are subject 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. All services billed to Neighborhood for reimbursement are subject to audit.

Effective dates noted reflect the date the long standing policy was documented or updated to assist with provider education, unless otherwise noted. Neighborhood reserves the right to update this policy at any time.

## Document History

| Date | Action |
|---|---|
| 3/1/2018 | Policy created and effective. |

## References

[i] R23-17.4-ALR
[ii] NUCC; NUBC; ANSI X12
[iii] AMA CPT Editorial Panel; CMS ICD-10-CM; AAPC HCPCS Level II
[iv] 3.3.2.5 - Amendments, Corrections and Delayed Entries in Medical Documentation
[v] CMS 3.3.2.4 - Signature Requirements