
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

- Medicaid** *excluding Extended Family Planning (EFP)*
- Commercial**
- Dual CONNECT (Coordination only D-SNP)**
- INTEGRITY for Duals (Fully Integrated D-SNP)**

Prerequisites

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 [Assisted Living Clinical Medical Policy](#).

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.

Assisted Living includes three tiered levels of care. Refer to the Assisted Living Clinical Medical policy or the EOHHS Assisted Living Certification Standards for clinical criteria for each tier.

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
- Other services that are similar or duplicative in nature



Neighborhood reserves the right to deny claims if the incorrect level of care tier is submitted or does not match what the member is approved for by RI EOHHS. Members without a Long-Term Services and Supports (LTSS) waiver are excluded from this benefit.

Claim Submission

Claims must be billed using the 837 Professional file format (CMS-1500).

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.

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

Patient share will be applied and is deducted from the benefit allowed amount at the time of payment adjudication. Providers should submit the claim with total billed charges, including patient share.

Coding

The inclusion of a code in this policy does not guarantee coverage or reimbursement. Please bill us in accordance with the member’s tiered level designation per RI EOHHS/DHS.

CPT Code	Description
T2031	Assisted living, Tier A Facility
T2031-UB	Assisted living, Tier B Facility
T2031-UC	Assisted living, Tier C Facility

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.

Neighborhood processes Dual CONNECT and INTEGRITY for Duals in accordance with CMS Medicare guidelines. Refer to [CMS Medicare guidance](#) for complete rules and claims processing policies.



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
01/01/26	Annual Review Date. Updated policy template to include new lines of business. Added claim submission requirements. Updated content throughout policy to incorporate LTSS language.
06/09/25	Annual Review Date. Updated coverage exclusions to include correct level of care tier.
07/01/24	Annual Review Date. No content changes
03/29/23	Annual Review Date. No content changes.
03/16/22	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.
03/01/18	Policy Created and Effective