Priority Health	BILLING POLICY No. 185
Custodial Care	
Date of origin: January 1, 2026	**Review dates: None yet recorded**

DEFINITION

Custodial care is non-skilled care that focuses on assisting with activities that do not require continued attendance of medical professionals. This policy provides billing guidance for custodial care services covered under the Highly Integrated Dual Eligible Special Needs Priority Health plan.

POLICY SPECIFIC INFORMATION

The custodial care benefit under the HIDE SNP plan covers daily care charges for a member in a nursing facility once the Medicare part A benefit is exhausted or when skilled care is no longer warranted. Any service provided during this stay that is not separately payable under Medicare Part B is considered part of the daily care reimbursement and not separately payable. To be eligible for this benefit, a member must meet criteria for non-skilled nursing care and have an approved Level of Care Determination (LOCD) filed in the Community Health Automated Medicaid Processing System (CHAMPS). Prior Authorization must be obtained from Priority Health.

Patient Pay Amount

Members' financial resources are assessed when eligibility for long-term care is determined. The assessment results in a dollar amount that a member is expected to pay for their daily care called the Patient Pay Amount (PPA). The PPA must be included on the claim even if the PPA = $0.

Ventilator Dependent Care Units (VDCU)

Members that are ventilator dependent and not expected to be weaned may be placed in a specially dedicated bed or unit of a facility. Facilities must bill the distinct NPI code for this unit.

Complex Care

Similar to VDCU, when a member requires more complex care than a standard patient, the nursing facility can request authorization for a complex care admission.

Hospital Leave Days

Reimbursement may be provided for a nursing facility to hold a bed for up to ten days during a member's temporary absence from the facility due to admission to the hospital for emergency medical treatment. Reimbursement will occur only when the facility's total available bed occupancy is 98 percent or more on the day the member leaves the facility. The member must return to the nursing facility in 10 days or less in order for the nursing facility to bill for hospital leave days. If the member does not return in 10 days, the claim should be billed with a discharge date that matches the day they were admitted to the acute care hospital.

Therapeutic Leave Days

If the member has a temporary absence from the nursing facility for therapeutic reasons approved by a physician, reimbursement is provided to the facility to hold the bed for a total of 18 days maximum during a 365-day period. Therapeutic leave is for nonmedical reasons. If a member does not return from a therapeutic leave, the member must be discharged on the date they left the facility. The date of admission and the date of discharge may not be billed as therapeutic leave days.

Non-Covered Leave Days
Reimbursement is not provided to hold a bed for reasons other than emergency transfer to a hospital or therapeutic leave. The member will be liable for non-covered leave days if they are informed the hold is non-covered; they agree to have the bed held and agree in writing to pay the facility at a specified rate.

Return to Previous Bed:
When a member has been residing in a nursing facility and needs to be admitted to an acute care hospital, upon discharge from the hospital, the member may choose to forgo their Medicare SNF benefit and return to their previous nursing facility status.

Hospice:
Hospice room and board are covered for a member residing in a nursing facility. Traditional Medicare is responsible for other related services.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Coding specifics

- Room & Board:
  - Bill type 21x
  - Revenue Code 0110 or 0120 depending on room type
  - Room and Board from and to dates on the line must match the Statement from and through dates on the claim header.
  - Only a single calendar month may be billed on one claim.
  - Value Code 81 with a total number of days not covered by Medicare.
  - When Medicare SNF benefits have been exhausted, Occurrence Code A3 with the date Medicare benefits were exhausted.
  - When Medicare no longer applies due to the end of skilled care, Occurrence Code 22 with the date of care transitioned to custodial care.
  - PPA Value Code D3 with the amount collected from the member, even when PPA = 0
  - PPA Offset value codes:
    - 25 Offset to Payment Amount – Prescription Drugs
    - 26 Offset to Payment Amount – Hearing and Ear Services
    - 27 Offset to Payment Amount – Vision and Eye Services
    - 28 Offset to Payment Amount – Dental Services
    - 29 Offset to Payment Amount – Chiropractic Services
    - 33 Offset to Payment Amount – Podiatric Services
    - 34 Offset to Payment Amount – Other Medical Services
- Ventilator Dependent Care Units:
  - Revenue code 0110 and distinct NPI must be billed
- Complex Care Admission
  - Revenue code 0120
  - A Single Case Agreement must be established with Priority Health Contracting Department.
- Hospital Leave Days
  - Revenue Code 0185
  - Occurrence Code 74 includes the dates representing the leave days.

- Therapeutic Leave Days:
    - Revenue Code 0183
    - Occurrence Code 74 includes dates representing the leave days.
- Non-Covered Leave Days:
    - Non-Covered days must be subtracted from Room and Board line.
    - Value Code 74
- Return to Previous Bed:
    - Revenue Code 0160
- Medicare Part B covered services
    - Bill Type 22x
    - CMS Outpatient Revenue Code, Procedure Code, and Modifier billing rules must be followed.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Resources

MedicaidProviderManual.pdf

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
3/27/2026	New Policy