Adult Day Health (ADH)
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Adult Day Health (ADH)		
MNG#: 073	**☒SCO ☒ One Care** **☐MA Medicare Premier** **☐ MA Medicare Value** **☐ RI Medicare Preferred** **☐ RI Medicare Value** **☐ RI Medicare Maximum**	**Prior Authorization Needed?** **☒ Yes (always required)** **☐ Yes (only in certain situations. See this MNG for details)** **☐ No**
Clinical: ☒	**Operational: ☒**	**Informational: ☐**
Benefit Type: **☐Medicare** **☒ Medicaid**	**Approval Date:** 7/1/2021;	**Effective Date:** 9/28/2021
Last Revised Date: 5/13/2023;	**Next Annual Review Date:** 7/1/2022; 5/13/2024;	**Retire Date:**

OVERVIEW:

Adult Day Health (ADH) is a community-based, non-residential service that supports members with physical, cognitive, complex medical, and/or behavioral health impairments by providing nursing care, supervision, and health related support services in a structured setting. The program not only supports members who attend the day program but supports families and other caregivers by providing them with respite while the member attends the program. ADH programs provide transportation from the member's home to the ADH program, as well as transportation from the ADH program to the member's home, including assisting the member while entering and exiting the vehicle, as appropriate.

ADH program offers a variety of bundle services, that include, nursing services and health oversight, therapy services (physical therapy, occupational therapy, and speech/language services), assistance with activities of daily living (ADLs), nutritional and dietary services (a hot meal, special diets, an alternate food choice, and two snacks – morning and afternoon), counseling services, therapeutic activities, and case management. The services are provided to the member in a structured group setting at the ADH provider's program site with the general goal of meeting the assessed skilled services and/or activities of daily living (ADL) needs of the member.

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DEFINITIONS:

- Activities of Daily Living (ADLs) - Fundamental personal-care tasks performed daily as part of an individual's routine of self-care. ADLs include, but are not limited to, eating, toileting, dressing, bathing, transferring, and mobility/ambulation.

- Clinical Assessment - The screening process of documenting a member's need for ADH using a tool designated by the MassHealth agency and that forms the basis for prior authorization.

- Clinical Evaluations - Nursing, fall risk, nutritional, skin, and other clinical or psychosocial evaluations conducted by the interdisciplinary team that serve as the basis for the development of the ADH plan of care.

- Hospital – a facility that is licensed or operated as a hospital by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health that provides diagnosis and treatment on an inpatient or outpatient basis for patients who have any of a variety of medical conditions.

- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) – a facility, or distinct part of a facility, that provides intermediate care facility services as defined under 42 CFR § 440.150, and that meets federal conditions of participation, and is licensed by the State primarily for the diagnosis, treatment, or rehabilitation for individuals with intellectual disabilities; and provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration for health or rehabilitative services to help individuals function at their greatest ability.

- Member — a person who is enrolled in the CCA One Care or Senior Care Options (SCO) plan

- Nursing Facility – an institution (or a distinct part of an institution) which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services for the rehabilitation of injured people, people with disabilities, or sick persons, or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services that the meets the requirements of Sections 1919 (a), (b), (c) and (d) of the Social Security Act and is licensed under and certified by the Massachusetts Department of Public Health.

- Primary Care Provider (PCP) — a physician or a physician assistant or nurse practitioner who practices under the supervision of a physician.

- Provider - An organization that meets the requirements of 130 CMR 404.000: Adult Day Health Services and 101 CMR 310.00: Rates for Adult Day Health Services and the MassHealth Adult Day Health (ADH) and contracts with MassHealth as the provider for ADH.

- Significant Change — a major change in the member's status that
  (1) is permanent or will not normally resolve itself without further interventions;
  (2) impacts more than one area of the member's health status; and
  (3) requires an interdisciplinary review or revision of the care plan.
  A significant change is presumed when the provider is seeking a change in service payment level.

DECISION GUIDELINES:

Clinical Coverage Criteria:

Commonwealth Care Alliance (CCA) follows applicable Medicaid regulations and bases its determination of medical necessity for ADH on clinical data, including, but not limited to, indicators that would affect the relative risks and benefits of the service for the member and needs identified through clinical assessment.

Clinical Eligibility Criteria:

1. The member's Primary Care Practitioner (PCP) ordered ADH; **and**

2. The member has one or more chronic or post-acute medical, cognitive, or mental health condition(s) identified by the member's PCP that require active monitoring, treatment or intervention and ongoing observation and assessment by a nurse, without which the member's condition will likely deteriorate; **and**

3. The member requires the ADH program to provide one or both of the following:
   a. at least one of the *Skilled Services (see below)* ordered by a physician; or
   b. assistance with one or more *qualifying ADLs (see below)* for, in which the member either requires hands-on physical assistance with the ADL activity, or the member can perform the ADL activity, but requires cueing and supervision throughout the performance of the task to complete it. The ADL assistance must be needed at least daily or on a regular basis at the ADH.

4. Skilled services may include:

a. Skilled service 1. intravenous, intramuscular, or subcutaneous injection, or intravenous feeding;
b. Skilled service 2. nasogastric-tube, gastrostomy, or jejunostomy feeding;
c. Skilled service 3. nasopharyngeal aspiration and tracheostomy care. However, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services;
d. Skilled service 4. treatment and/or application of dressings when the physician has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions);
e. Skilled service 5. administration of oxygen on a regular and continuing basis when the member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema);
f. Skilled service 6. skilled-nursing intervention including observation, evaluation or assessment, treatment and management to prevent exacerbation of one or more chronic medical and/or behavioral health conditions at high risk for instability. Intervention must be needed at frequent intervals throughout the day;
g. Skilled service 7. skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery, safety and the stabilization of the member’s complex social determinants of health;
h. Skilled service 8. insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter. A urethral catheter, particularly one placed for convenience or for control of incontinence, does not justify a need for skilled-nursing care. However, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled-nursing care. In such instances, the need for a urethral catheter must be documented and justified in the member’s medical record (for example, cancer of the bladder or a resistant bladder infection);
i. Skilled service 9. Administration oversight, and management of medication by a licensed nurse including monitoring of dose, frequency, response and adverse reactions;

j. Skilled service 10. evaluation, implementation, oversight and supervision by a licensed nurse of a behavior management plan and staff intervention required to manage, monitor, or alleviate the following types of behavior:
    i. wandering: moving with no rational purpose, seemingly oblivious to needs or safety; ongoing exit seeking behaviors; or elopement or elopement attempts;
    ii. verbally abusive behavioral symptoms: threatening, screaming, or cursing at others;
    iii. physically abusive behavioral symptoms: hitting, shoving, or scratching;
    iv. socially inappropriate or disruptive behavioral symptoms: disruptive sounds, noisiness, screaming, self-abusive acts, disrobing in public, smearing or throwing food or feces, rummaging, repetitive behavior, eating non-food items, or causing general disruption, including difficulty in transitioning between activities;
    v. inability to self-manage care;
    vi. pattern of disordered thinking, impaired executive functioning, confusion, delusions or hallucinations, impairing judgment and decision-making leading to lack of safety awareness and unsafe behavior and requiring frequent intervention during the day to maintain safety.
k. Skilled service 11. medically necessary measurements of intake and output based on medical necessity to monitor and manage a chronic medical condition;
l. Skilled service 12. gait evaluation and training administered or supervised by a registered physical therapist while at the ADH provider for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific timeframe;
m. Skilled service 13. certain range-of-motion exercises may constitute skilled physical therapy only if they are part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical-therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record);
n. Skilled service 14. hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications; and
o. Skilled service 15. physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services

must be ordered by a physician and be designed to achieve specific goals within a given time frame.

5. Qualifying Activities of Daily Living (ADLs) may include:
    a. bathing—a full body bath or shower or a sponge (partial) bath which may include washing and drying of face, chest, axillae (underarms), arms, hands, abdomen, back and periarea that may include personal hygiene such as combing or brushing of hair, oral care, shaving, and when applicable applying make-up;
    b. toileting—member is incontinent (bladder or bowel) **or** requires scheduled assistance or routine catheter or colostomy care;
    c. transferring—member must be assisted or lifted to another position or the member can perform the ADL activity, but requires cueing and supervision throughout the performance of the task to complete it;
    d. mobility (ambulation) —member must be physically steadied, assisted or guided in mobility, or is unable to self-propel a wheelchair appropriately without the assistance of another person;
    e. eating member requires constant supervision and cueing during the entire meal or physical assistance with a portion or all of the meal.

DETERMINATION OF NEED

Basic or Complex Levels of Care:

1. There are two payment rates for ADH, Basic and Complex. CCA will make a determination based upon the clinical eligibility criteria. ADH providers may request the level of payment assuming the clinical documentation submitted with the prior authorization demonstrates the following.
    a. Basic Payment. For a member to qualify for Basic payment:
        i. The member must need at least one skilled service (see *Skilled Services 1-15*), or assistance with at least one of the Qualifying ADLs described in the Clinical Eligibility Criteria section.
        ii. The ADH provider must meet at least one of the qualifying needs while the member is in attendance at the ADH program.
    b. Complex Payment. For a member to qualify for Complex payment
        i. The member must need one or more of Skilled Services 1-5 or 8, daily as described in the Clinical Eligibility Criteria section, or a combination of **at least three** of the following needs including at least one of the Skilled Services noted below:
            1. One or more ADL listed under Clinical Eligibility Criteria; and
            2. One or more skilled service 9-12 or 15 as described under the Clinical Eligibility Criteria section.

ii. The member must need the services while in attendance at the ADH program and the ADH provider must provide the services in a manner consistent with the plan of care as directed by the ADH nurse.

Prior Authorization:

1. Prior authorization determines the medical necessity for ADH as described under the above Clinical Eligibility Criteria, and in accordance with 101 CMR 404.

2. As a prerequisite for payment of ADH, the ADH provider must obtain prior authorization before the first date of service delivery and at various intervals. Requests for prior authorization must be submitted to CCA as outlined in the CCA Provider Manual.

3. ADH providers must submit requests for prior authorization at the following intervals:
    a. Before the first date of service delivery (initial authorization),
    b. Before an existing authorization period ends by submitting a new authorization request (re-authorization) at least 21 calendar days before the authorization end date, or
    c. Upon significant change where the payment level may need to change for Basic to Complex.
    d. Initial Authorization (Before Admission). ADH providers must request and obtain prior authorization before the first date of service delivery. CCA may take up to 21 calendar days to act on a request unless the request is expedited. Services will not be approved retroactively.
    e. Subsequent Authorizations (Re-authorization). For members with existing prior authorization, ADH providers must submit a request for prior authorization at least 21 calendar days before the member's authorized end date. Services will not be approved retroactively if requests are submitted after the member's existing prior authorization expires.
    f. Transfer from another ADH provider. The accepting ADH provider must submit a new prior authorization within 5 business days before the start of service.
    g. Significant Change. ADH providers must timely submit a request for prior authorization upon a significant change and include a current assessment and the PCP's order requesting the adjusted services.

Prior Authorization Documentation:

1. Documentation of medical necessity for ADH must be part of each prior authorization submission and include, at a minimum, the following:
    a. The member must have a medical or mental condition that involves one or more physiological systems requiring at least one Skilled Service and/or assistance with one or more Qualifying ADLs as described in the Clinical Eligibility Criteria above; AND

b. CCA Standardized Prior Authorization Request Form
c. PCP order identifying the Skilled Service and/or Qualifying ADLs (providers may use the *MassHealth Adult Day Health Primary Care Provider (PCP) Order Form*)
d. Clinical assessment to support eligibility for ADH and level of care (basic or complex). Documentation from the ADH provider will be reviewed and validated against the most recent CCA Clinical Assessment on record and other clinical documentation.
e. Other documentation to support the medical necessity review: Clinical documentation, evaluations or assessments that support the signs and symptoms pertinent to the chronic or post-acute medical, cognitive, or mental health condition(s) identified by the member's PCP that require active monitoring, treatment or intervention and ongoing observation and assessment by a nurse, without which the member's condition will likely deteriorate; describe the member's condition and support the members' need for ADH.

LIMITATIONS/EXCLUSIONS:

1. CCA does not pay an ADH provider nor consider ADH to be medically necessary under certain circumstances. Examples of circumstances include, but are not limited to, the following:
    a. For any portion of a day during which the member is receiving services provided by a Home Health Agency while the member is in attendance at the ADH program under 130 CMR 403.000
    b. When the member is a resident or inpatient of a hospital, nursing facility, or intermediate care facility for the intellectually disabled; except on dates of admission and discharge;
    c. If the provider has not received prior authorization from CCA;
    d. For any canceled program days or any time periods missed by a member for any reason; and
    e. For any portion of a day during which the member is absent from the site, unless the program documents that the member was receiving services from the program staff outside of the ADH program in a community setting.

AUTHORIZATION:

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not signify that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

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HPCPS Codes	Description
S5102	Adult Day Health – Basic; Per Diem
S5102 TG	Adult Day Health – Complex; Per Diem
S5101	Adult Day Health – Basic; Per 3 Hours
S5101 TG	Adult Day Health -Complex; Per 3 Hours
T2003	Adult Day Health Transportation
T2003 U6	Transportation – Wheelchair

REGULATORY NOTES:

Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state specific MNG criteria shall supersede these criteria. This MNG references the specific regulations, coverage, limitations, service conditions, and/or prior authorization requirements in the following:

DISCLAIMER

This Medical Necessity Guideline is not a rigid rule. As with all of CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

RELATED REFERENCES:

- 130 CMR 404.000 MassHealth Adult Day Health Services and Subchapter iv Adult Day Health Services Manual
- 101 CMR 310.00 Rates for Adult Day Health Services
- 105 CMR 158.000 Licensure of Adult Day Health Programs
- MassHealth Guidelines for Medical Necessity Determination for Adult Day Health (ADH) Services
- MassHealth Adult Day Health Primary Care (PCP) Order Form

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ATTACHMENTS:

EXHIBIT A	
EXHIBIT B	

REVISION LOG:

REVISION DATE	DESCRIPTION

APPROVALS:

Laura Jankowski	Manager, Utilization Management
CCA Senior Clinical Lead [Print]	**Title [Print]**
Laura Jankowski	5/11/2023
Signature	**Date**
CCA Senior Operational Lead [Print]	**Title [Print]**
Signature	**Date**
Nazlim Hagmann, MD	Chief Medical Officer
CCA CMO or Designee [Print]	**Title [Print]**
Nazlim Hagmann	5/11/2023
Signature	**Date**