Supportive Day Program
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Supportive Day Program		
MNG #: 105	☒**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:** 03/03/2022;	**Effective Date:** 8/23/2022;
Last Revised Date: 9/14/2023;	**Next Annual Review Date:** 03/03/2023; 9/14/2024;	**Retire Date:**

OVERVIEW: Supportive Day Programs, is a Community-Based service. The program is non-medical and aims to provide a care environment that supports individuals in their emotional, cognitive, and physical well- being. The program assists individuals, who would otherwise be socially isolated, through a structured program of activities designed to stimulate and engage members in maintaining optimal functioning in the community. Participants will have the opportunity to explore new interests and socialize in a safe & supportive atmosphere. The program can serve as a form of daily respite for caregivers who work. **This service is not intended to support the member that has ADLs**

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.

Adult Day Health (ADH): Health care and supervision, restorative services, and socialization for elders who require skilled nursing or therapy, or assistance with Activities of Daily Living, nutrition, and personal care.

Assisted Living Facility (ALF): A residence that includes 24-hour on-site response capability that offers a combination of housing, meals and personal care and support services to adults.

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

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Clinical Evaluations: Nursing, Geriatric Support Services Coordinator (GSSC) assessment, medical and other clinical or psychosocial evaluations.

Frail Elder Waiver (FEW): A member who is certified by the MassHealth agency or its agent to be in need of nursing-facility services that meet age and financial eligibility requirements; is permanently and totally disabled, who receives one or more services, administered by the Executive Office of Elder Affairs, at home.

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

Respite Care: The provision of one or more other Home Care Program Services to temporarily relieve a Caregiver in emergencies, or in planned circumstances, to relieve the Caregiver of the daily stresses and demands of caring for a Consumer.

DECISION GUIDELINES:

Clinical Coverage Determination:

CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses InterQual Smart Sheets, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists.

Clinical Criteria:

1. Commonwealth Care Alliance may cover Supportive Care when the following are met:
    a. The member requires a non-medical, supportive environment that encourages socialization and structured programming to maintain the health and welfare of the member, and
    b. Member is independent with ADLs; and
    c. Member is able to administer their own medication when needed; and
    d. Member is alone for long periods of time

DETERMINATION OF NEED:

Prior Authorization:

1. Prior Authorization determines the medical necessity for Social Day Program supports as described above, under the Clinical Criteria section.
2. Requests for prior authorization must be submitted to CCA as outlined in the CCA Provider Manual
3. As a prerequisite for payment of Supportive Day Program services, prior authorization must be

obtained before the first date of service delivery and at various intervals. CCA may take up to 14 days to process a request.

4. Prior authorization must be submitted at the following intervals:
   a. Initial PA – Before the first date of service delivery; services will not be approved retroactively
   b. Re-authorization – For members with an existing prior authorization a new authorization request should be submitted at least 14 calendar days before the existing authorization end date

Prior Authorization Documentation:

1. Documentation that supports a member's need for a non-medical, supportive environment that encourages socialization and structured programming that allows the member to maintain optimal function in the community. Documentation must include, at a minimum, one or more of the following:
   a. Clinical Assessment.
   b. Member's Care Plan.
   c. Clinical Evaluation(s); or
   d. Other clinical documentation to support the medical necessity review, such as, but not limited to PCP progress notes, Behavioral Health notes.

LIMITATIONS/EXCEPTIONS:

Limitations: CCA does not cover Supportive Day Program when:

1. The member is a resident of an Assisted Living Facility or inpatient of a hospital or nursing facility.
2. The member is receiving Day Habilitation, Adult Day Health or any other comparable day program.
3. The Supportive Day Program provider has not received prior authorization from CCA.

Exceptions:

SCO members on the Frail Elder Waiver (FEW) may require this service in their care plan to remain eligible for the waiver. This service may be approved as an exception to existing limitations/exclusions in those instances. Consult with the GSSC for additional information.

For individuals requiring ADL and/or IADL support, typically Adult Day Health is a more appropriate service as it provides support with ADLs and medication administration. However, Supportive Day Care may be considered if the member (1) has a long history of attending the program, (2) the service can be clearly linked to the member's care plan goals, and (3) the member is able to safely attend the Supportive Day Program despite functional limitations.

AUTHORIZATION:

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing 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).

HCPCS Codes	Description
S5101	Supportive Day Program, SCO only (Supportive Care)

REGULATORY NOTES:

Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. 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:

130 CMR 630.000 Home- and Community-Based Services Waiver Services

130 651 CMR 3.00 Home Care Program, Home Care Program Service Definitions: Provider Agreement Appendix A.

RELATED REFERENCES:

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.

ATTACHMENTS:

EXHIBIT A	
EXHIBIT B	

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REVISION LOG:

REVISION DATE	DESCRIPTION
8/15/2023	Updated template, revised Overview section, added 'Definitions' section, Revised titles under Decision Guidelines section and added sub sections – Prior Authorization and Prior Authorization Documentation sections, revised Limitation/Exceptions sections, removed" Key Care Planning Considerations" section, updated Regulatory Notes section.

APPROVALS:

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