Guidelines for Medical Necessity Determination for Adult Day Health (ADH) Services

These Guidelines for Medical Necessity Determination (Guidelines) identify the clinical information that MassHealth uses to determine medical necessity for Adult Day Health (ADH) services. These Guidelines are based on generally accepted standards of practice, review of medical literature, and federal and state policies and laws applicable to Medicaid programs.

MassHealth ADH providers (Providers) should consult MassHealth regulations at 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) Manual* for information about coverage, limitations, service conditions, and Prior-Authorization (PA) requirements. Providers serving members enrolled in the Senior Care Options (SCO), One Care, or the Program of All-inclusive Care for the Elderly (PACE) should refer to the SCO, One Care, or PACE medical policies for covered services.

MassHealth requires PA (see Section III) for ADH services. MassHealth reviews requests for PA on the basis of medical necessity. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including member eligibility, other insurance, MassHealth's administrative and billing regulations and guidance, and MassHealth's ADH program regulations and guidance.

1 SECTION I. GENERAL INFORMATION

ADH is a community-based, non-residential service that provides skilled services and assistance with Activities of Daily Living (ADL) in a structured setting to support MassHealth members.

ADH is designed to meet the assessed skilled and ADL needs of members with physical, cognitive, complex medical, and/or behavioral health impairments. ADLs are those routine self-care activities that persons generally perform everyday such as eating and toileting. Skilled needs are those needs met by services that fall within the professional disciplines of nursing and physical, occupational, and speech therapies.

MassHealth considers approval for coverage of ADH on an individual, case-by-case basis, based on clinical need in accordance with 130 CMR 404.000: *Adult Day Health Services* and 101 CMR 310.00: *Rates for Adult Day Health Services*.

2 SECTION II. CLINICAL GUIDELINES

A. CLINICAL ELIGIBILITY CRITERIA

MassHealth 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 completed and interpreted by a registered nurse using a MassHealth-specified clinical assessment tool.

The MassHealth agency considers a member clinically eligible for MassHealth coverage of ADH when the member is 18 years of age or older and meets the following 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 skilled service listed in 130 CMR 404.405(B): *Skilled Services (see below)*; or
    b. assistance with one or more qualifying ADLs as listed in 130 CMR 404.405(C): *Qualifying Activities of Daily Living for ADH Services*, 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.

SKILLED SERVICES

Examples of skilled services include

SKILLED SERVICE 1. Intravenous, intramuscular, or subcutaneous injection or intravenous feeding.

SKILLED SERVICE 2. Nasogastric-tube, gastrostomy, or jejunostomy feeding.

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.

SKILLED SERVICE 4. Treatment, wound care and/or application of dressings to wounds including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions when the skills of a registered nurse are needed. This includes physician-prescribed irrigation, topical application of medication, and/or use of sterile dressings for the treatment of conditions such as deep decubitus ulcers or other skin disorders.

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).

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 conditions at high risk for instability. Intervention must be needed at frequent intervals throughout the day.

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 and safety, and the stabilization of their complex social determinants of health. Examples include nutritional planning, administration of special diets, and nutritional cueing, supervision and monitoring for members with the need for special diets; supervision and cueing or hands on assistance with maintaining appropriate fluid intake; or implementing and monitoring a positioning schedule as written in the care plan.

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).

SKILLED SERVICE 9. Administration, oversight, and management of medication by a licensed nurse including monitoring of dose, frequency, response and adverse reactions.

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.

SKILLED SERVICE 11. Measurements of intake and output based on medical necessity to monitor and manage a chronic medical condition.

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.

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).

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.

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 timeframe.

ACTIVITIES OF DAILY LIVING (ADL)

Qualifying ADLs are

BATHING. To be a qualifying ADL, the member must need assistance with taking a full-body (front, back, upper and lower body) bath or shower or a sponge (partial) bath that may include washing and drying of face, chest, axillae (underarms), arms, hands, abdomen, back and peri-area. In addition, the ADH provider may assist a member with personal hygiene such as combing or brushing of hair, oral care (including denture care and brushing of teeth), shaving, and, when applicable, applying make-up. Merely washing an individual's hands and face or assisting with personal hygiene alone does not meet clinical eligibility for receipt of ADH.

TOILETING. To be a qualifying ADL, the member must be incontinent of bladder and/or bowel or require scheduled assistance or routine catheter or colostomy/urostomy care.

TRANSFERRING. To be a qualifying ADL, the member must need assistance or must be lifted to move from one position to another. For example, the member requires assistance to move from a wheelchair to the commode.

MOBILITY (AMBULATION). To be qualifying ADL, the member must need to be physically steadied, assisted or guided during ambulation, or is unable to self-propel a wheelchair appropriately without the assistance of another person.

EATING. To be a qualifying ADL, the member must require constant supervision and cueing during the entire meal or the member needs to be physically assisted in eating (fed) for all or a portion of a meal. For example, eating would be a qualifying ADL for members who are physically capable of eating but have a cognitive impairment that requires constant cueing and supervision to eat, but eating would not be a qualifying ADL for members who need help only with cutting up food or another type of set-up. In addition eating is not a qualifying ADL if the Member just has a limited diet, such as a Member with diabetes.

B. NON-COVERAGE

MassHealth 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:

1. 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: *Home Health Agency* that are duplicative of services covered under ADH;

2. 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;

3. If the provider has not received prior authorization from the MassHealth agency or its designee;

4. For any canceled program days or any time periods missed by a member for any reason; and

5. 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.

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SECTION III. PRIOR AUTHORIZATION FOR ADULT DAY HEALTH

PA determines the medical necessity for ADH as described under 130 CMR 404.405: *Clinical Eligibility Criteria* and in accordance with 130 CMR 450.204: *Medical Necessity*. As a prerequisite for payment of ADH, the ADH provider must obtain PA before the first date of service delivery and at various intervals. Requests for prior authorization for ADH must be submitted by an enrolled MassHealth ADH provider through the MassHealth LTSS Provider Portal (Provider Portal).

A. ADH providers must submit requests for PA at the following intervals:

   1. Initial Evaluation (Before Admission). ADH providers must request and obtain PA before the first date of service delivery. The MassHealth agency or its designee may take up to 21 calendar days to act on a request for PA for ADH, unless the request is expedited in accordance with section IV.B. Services will not be approved retroactively.

   2. Annual Evaluation (Re-evaluation). For members with existing PA, ADH providers must submit an annual request for PA 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 PA expires.

   3. Transfer from another ADH provider. The accepting ADH provider must submit a new PA within 5 business days before the start of service that complies with the requirements of Section III.A. *Note: It is **not** considered a transfer if a member remains with the same provider entity but moves from one of the ADH provider's site locations to another one of its site locations.*

   4. On Significant Change[1] . ADH providers must timely submit a request for PA upon a significant change and include a current assessment and the PCP's order requesting the adjusted services.

B. There are two MassHealth payment rates for ADH, Basic and Complex. The MassHealth agency or its designee will make the determination based upon the clinical eligibility criteria set forth in 130 CMR 404.405: *Clinical Eligibility Criteria* and 130 CMR 404.414: *Conditions of Payment*. ADH providers may request the level of payment for ADH (as described under 130 CMR 404.414(D): *ADH Payment Levels*)).

1 A "Significant Change" is a major change in the member's status that (A) is permanent; (B) impacts more than one area of the member's health status; and (C) requires an interdisciplinary review or revision of the care plan. A significant change is presumed when a member authorized to receive ADH does not receive ADH for 90 days or more, or when the provider is seeking a change in service payment level.

1. **BASIC PAYMENT:** For a member to qualify for Basic payment

   a. The member must need at least one skilled service from Section II.A.2.a. above, or assistance with at least one of the ADLs described in Section II above, and,

   b. The ADH provider must meet at least one of the qualifying needs while the member is in attendance at the ADH program.

2. **COMPLEX PAYMENT:** For a member to qualify for Complex payment

   a. The member must need one or more of Skilled Services 1-5 or 8, daily as described in Section II above, or a combination of **at least three** of the following needs including at least one from (ii) below:

      (i) ADLs listed above in Section II A; and

      (ii) Skilled Services 1-5, 8-12 or 15 described in Section I. A.1 a. above.

   b. 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.

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SECTION IV. SUBMITTING FOR PRIOR AUTHORIZATION

A. DOCUMENTATION

Requests for PA for ADH must be in the form and format as specified by the MassHealth agency and be submitted electronically by the MassHealth ADH provider using the Provider Portal. Each submission must be accompanied by all necessary clinical documentation supplied by the ADH provider and PCP that supports the medical necessity for the requested service(s).

Documentation of medical necessity for ADH must include, at a minimum, the following:

1. ASAP RN clinical eligibility form (for Initial PA and Transfers only), AND

2. PCP order (for all PA submissions); AND

3. MassHealth designated clinical assessment form (to support Complex level of care for Initial PA and revaluations, significant changes and transfers); AND

4. 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.

The member's clinical assessment must be performed no more than 90 calendar days before the date of the PA request. MassHealth will deny all PA requests that are accompanied by clinical assessments that are more than 90 calendar days old, with direction to the provider to obtain a more current clinical assessment.

B. PA ADJUDICATION

The MassHealth agency or its designee may take up to 21 calendar days to act on a request for PA for ADH, unless the request is expedited in accordance with this section.

If an ADH provider submits a PA request that has missing, incomplete, or inconsistent documentation, the MassHealth agency will notify the ADH provider of the relevant requirements, and inform the provider that the MassHealth agency will act on the request within the 21-calendar day limit if it receives the required information within four calendar days after its request. If the MassHealth agency does not receive the required information within four calendar days, the MassHealth agency's decision may be delayed by the number of days that pass between the four calendar day cutoff date and the date that the MassHealth agency receives the necessary information.

If there is an urgent need for PA, the provider should explain in the Provider Portal the medical necessity for expediting the PA request.

An ADH provider may request an expedited PA only under the following circumstances:

1. The member is being discharged from a hospital

2. The member is being discharged from a nursing facility;

3. Urgent need such as illness or death of a caregiver.

When requesting an expedited PA, the ADH provider must submit the request and include the same documentation as described in Section IV. Upon receipt of the complete and comprehensive expedited PA request, MassHealth or its designee will decide within 72 hours.

C. NOTICE OF APPROVAL, DENIAL OR MODIFICATION OF A PRIOR AUTHORIZATION REQUEST

1. If the MassHealth agency approves a PA request for ADH, the MassHealth agency will send notice of the decision to the member and the ADH provider.

2. If the MassHealth agency denies or modifies a PA request for ADH, the MassHealth agency will send notice of its decision to the member and the ADH provider. The notice will state the reason for the denial or modification and will inform the member of the right to appeal and the appeal procedure in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

3. If the MassHealth agency defers a prior authorization request due to an incomplete submission or lack of documentation to support medical necessity, the MassHealth agency will notify the ADH provider of the deferral, and will inform the ADH provider of the reason for the deferral and provide an opportunity for the provider to submit the incomplete or missing documentation.

4. If the provider does not submit the required information within 21 calendar days of the date of deferral, the MassHealth agency will deny the prior authorization request and will send notice of its decision to the provider and the member. The notice will state the reason for the denial or modification, and will inform the member of the right to appeal and of the appeal procedure in accordance with 130 CMR 610.000. The provider may resubmit a new prior authorization request that includes all required documentation.

D. QUESTIONS

ADH providers who have questions regarding PA should contact the MassHealth Prior Authorization Help Line at (844) 685-5184. For enrollment or other questions, ADH providers should contact the MassHealth LTSS Provider Service Center (800) 862-8341.

Select References

MassHealth Adult Day Health Manual

MassHealth LTSS Provider Portal

These Guidelines are based on review of the medical literature and current practice in ADH. MassHealth reserves the right to review and update the contents of these Guidelines and references without limitation, including the emergence of new clinical evidence and medical technology.

This document was prepared for medical professionals to assist them in submitting documentation supporting the medical necessity of the proposed treatment, products or services. Some language used in this communication may be unfamiliar to other readers; in this case, they should contact their health-care provider for guidance or explanation.

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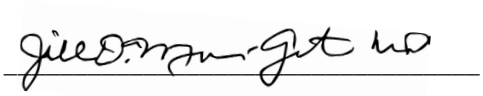
Approved by: 

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