

Adult Day Health Clinical Coverage Criteria

Description

Adult Day Health (ADH) is a community-based daytime service that provides nursing oversight, personal care, therapeutic services, meals, and structured activities based on the member's assessed medical, cognitive, behavioral, functional, and psychosocial needs. ADH supports the member's health, safety, functioning, and continued residence in the community.

Transportation Services

Transportation to and from the ADH program may be arranged and furnished subject to applicable MassHealth, product, authorization, and billing requirements. Transportation is not included in the ADH clinical service merely because the member is authorized for ADH.

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 comprehensive ADH provider assessment, signed and dated by the assessing registered nurse, that documents clinical eligibility, qualifying skilled services and ADL needs, the requested Basic or Complex level of care, and the basis for the plan of care and prior authorization request.

Primary Care Provider (PCP)- A qualified health care professional responsible for the member's primary care and authorized to order ADH services and identify the diagnoses, treatments, rehabilitation services, skilled services, and ADL assistance required at the program.

Significant Change- a major change in the member's status that is permanent, affects more than one area of the member's health status, and requires interdisciplinary review or revision of the plan of care. A significant change is presumed when the member has not received ADH services for 90 days or more or when the provider requests a change in payment level.

Policy

This Policy applies to the following Fallon Health products:

- ☐ Fallon Medicare Plus
- ☐ MassHealth ACO
- ☒ NaviCare HMO SNP
- ☒ PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
- ☐ Community Care

Prior authorization is required for Adult Day Health.

Prior authorization is required for ADH transportation when billed separately. Requests must document the member's transportation need and authorized ADH attendance schedule.

Authorization Requirements

- Prior authorization is required before services begin and before the current authorization expires.
- For NaviCare members, effective January 1, 2027, the ADH provider must submit complete initial, reauthorization, extension, significant-change, level-change, and provider-transfer requests directly to Fallon Health.
- A current clinical assessment is required initially, annually, upon significant change, and when required to support a level change or provider transfer.
- The new provider must obtain authorization before billing following a provider transfer.

- For PACE participants, ADH must be authorized and coordinated by the PACE interdisciplinary team.

Fallon Health Clinical Coverage Criteria

Fallon Health considers Adult Day Health (ADH) medically necessary when all of the following criteria are met and supported by the required documentation:

- The member has a chronic or post-acute medical, cognitive, or behavioral health condition that requires ongoing monitoring, treatment, intervention, or nursing oversight and is ordered by the PCP.
- The member requires at least one qualifying skilled service, assistance with one or more qualifying ADLs, or both, while attending the ADH program.
- Required services are included in the member's plan of care and support the requested Basic or Complex level of care.
- The clinical assessment and supporting documentation demonstrate medical necessity and the need for the requested level of care.
- ADH services must not duplicate another covered service provided during the same period of time.
- For members receiving hospice services, documentation must demonstrate that ADH services are medically necessary, coordinated with the hospice plan of care, and non-duplicative.

Required Documentation

Initial Authorization and Reauthorization

- Completed prior authorization request form.
- Current PCP order supporting ADH services.
- Current clinical assessment supporting eligibility and requested level of care.
- Current person-centered plan of care.
- Clinical documentation supporting skilled-service and/or ADL needs.
- Additional clinical records, orders, or coordination documentation as needed to determine medical necessity.
- For reauthorization, updated documentation demonstrating ongoing eligibility and continued need for services.
- Applicable ASAP documentation when required.

Authorization Update Requests

- Reauthorization requests must be submitted before the current authorization expires.
- Updated assessment and authorization documentation are required for significant changes, provider transfers, and level changes.
- The new provider must obtain authorization before billing.
- Submission of a request does not extend an existing authorization.

Qualifying Skilled Services

- Skilled Service 1: Intravenous, intramuscular, or subcutaneous injections, or intravenous infusion/feeding.
- Skilled Service 2: Nasogastric, gastrostomy, or jejunostomy tube feeding.
- Skilled Service 3: Nasopharyngeal aspiration or tracheostomy care. Routine long-term tracheostomy tube maintenance alone does not qualify as a skilled service.
- Skilled Service 4: Skilled wound care, treatment, or dressing changes requiring a registered

nurse, including care of ulcers, burns, surgical wounds, fistulas, tube sites, tumor erosions, or other complex skin conditions.

- Skilled Service 5: Oxygen administration requiring ongoing skilled observation and monitoring due to the member's medical condition.
- Skilled Service 6: Skilled nursing assessment, monitoring, treatment, or intervention required at frequent intervals to manage or prevent exacerbation of unstable medical or behavioral health conditions.
- Skilled Service 7: Skilled nursing management and evaluation of the care plan when the member's condition requires registered nurse oversight to ensure medically necessary interventions are effective and safely provided.
- Skilled Service 8: Insertion, replacement, irrigation, or management of catheters, including suprapubic catheters and medically necessary urethral catheters. The need for a urethral catheter must be clinically documented and justified.
- Skilled Service 9: Medication administration, monitoring, and management by a licensed nurse, including assessment of effectiveness and adverse reactions.
- Skilled Service 10: Implementation, monitoring, and oversight of a behavior management plan by a licensed nurse for members requiring frequent intervention due to wandering, elopement risk, aggression, disruptive behaviors, inability to self-manage care, impaired judgment, confusion, hallucinations, delusions, or other safety-related behavioral or cognitive conditions.
- Skilled Service 11: Medically necessary measurement and monitoring of intake and output to manage a chronic medical condition.
- Skilled Service 12: Physical therapist-directed gait evaluation and training for members with a recent neurological, muscular, or skeletal impairment, with documented treatment goals and expected outcomes.
- Skilled Service 13: Range-of-motion therapy provided as part of a documented treatment plan to restore or maintain mobility affected by disease or injury.
- Skilled Service 14: Hot pack, hydrocollator, paraffin bath, or whirlpool treatments requiring skilled therapy due to circulatory impairment, sensory deficits, wounds, fractures, or other complicating conditions.
- Skilled Service 15: Physical, occupational, speech-language, or other skilled therapy ordered by a physician and provided under the direction of a qualified therapist as part of a documented treatment plan with measurable goals.

Qualifying Activities of Daily Living

- Bathing: Full-body bathing, showering, or a partial sponge bath, including associated hygiene needs.
- Toileting: Assistance due to bladder or bowel incontinence, scheduled toileting, or routine catheter or colostomy care.
- Transferring: Physical assistance or lifting to another position or cueing and supervision throughout the task.
- Mobility or ambulation: Physical steadying, assistance, or guidance during mobility, or assistance when the member cannot appropriately self-propel a wheelchair.
- Eating: Constant supervision and cueing throughout the meal or physical assistance with part or all of the meal.

Levels of Care and Payment

- Basic Level
 - The member requires at least one qualifying skilled service or assistance with at least one qualifying ADL, and the ADH provider meets at least one of those qualifying needs while the

member is attending the ADH program. Services must be furnished in accordance with the member's plan of care and applicable ADH program requirements

- **Complex Level**
 - The member requires one or more of Skilled Services 1 through 5 daily, or 8 daily; or
 - Has a combination of at least three qualifying needs that includes:
 - At least one qualifying ADL; and
- At least one skilled service from Services 1 through 5, 8 through 12, or 15.
 - The service/assistance is required while the member attends ADH and is provided consistently with the plan of care under the direction of the ADH nurse.

Medicare Variation

N/A

MassHealth Variation

For MassHealth-covered ADH services, Fallon Health applies 130 CMR 404.000, 130 CMR 450.204, applicable MassHealth ADH medical-necessity guidelines and provider bulletins, and product-specific contractual requirements. Prior authorization is required before the first date of service and annually thereafter or upon significant change. A new clinical assessment is required annually and upon significant change. Approval does not establish or waive other prerequisites for payment.

Exclusions

Fallon Health determines that Adult Day Health (ADH) is not medically necessary and will not authorize payment to ADH providers under the following conditions, which include but are not limited to:

1. **Concurrent Home Health Services**
 - If the member is receiving services from a Home Health Agency or a similar provider during the same time they are attending the ADH program, as outlined in 130 CMR 403.000.
 - Any portion of a day during which the member receives services from a home health agency or similar provider while attending the ADH program, consistent with applicable MassHealth requirements.
2. **Institutional Residency or Inpatient Status**
 - If the member is currently admitted to a hospital, nursing facility, or an intermediate care facility for individuals with intellectual disabilities. Exceptions are made only for the dates of admission and discharge.
3. **Lack of Prior Authorization**
 - If the ADH provider has not obtained prior authorization from Fallon Health before delivering services.
4. **Program Cancellations or Member Absences**
 - If the ADH program is canceled or the member misses scheduled attendance for any reason, reimbursement will not be provided for those time periods.
5. **Absence from ADH Site Without Documented Off-Site Services**
 - If the member is not physically present at the ADH location, payment will only be considered if the provider documents that the member received ADH services from program staff in a community-based setting outside the facility.

Evidence Summary

N/A

Analysis of Evidence (Rationale for Determination)

N/A

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage.

CPT/HCPCS Codes

Code	Description
S5102	Day care services, adult; per diem. (Use for adult day health-basic level of care services over three hours per day)
S5102 TG	Day care services, adult; per diem. (Use for adult day health-complex level of care services over three hours per day)
S5101	Day care services, adult; partial per diem. (Use for adult day health-basic level of care services up to three hours per day)
S5101 TG	Day care services, adult; partial per diem. (Use for adult day health-complex level of care services up to three hours per day)
T2003	Nonemergency transportation, non-wheelchair (ambulatory) transportation. Use for transportation furnished on a single date or on consecutive dates. All transportation services must be billed as one-way trips; round trips should be billed as two one-way trips
T2003 U6	Nonemergency transportation, wheelchair transportation, encounter/trip. Use for transportation furnished on a single date or on consecutive dates. All transportation services must be billed as one-way trips; round trips should be billed as two one-way trips.

References

1. 130 CMR 404.000 MassHealth Adult Day Health Services and Subchapter iv Adult Day Health Services Manual <https://www.mass.gov/doc/130-cmr-404-adult-day-health-services/download>
2. 101 CMR 310.00 Rates for Adult Day Health Services <https://www.mass.gov/doc/101-cmr-310-rates-for-adult-dayhealth-services/download>
3. 105 CMR 158.000 Licensure of Adult Day Health Programs <https://www.mass.gov/doc/105-cmr-158-licensure-ofadult-day-health-programs/download>
4. MassHealth Guidelines for Medical Necessity Determination for Adult Day Health (ADH) Services <https://www.mass.gov/doc/guidelines-for-medical-necessity-determination-for-adult-day-health-adh-0/download>
5. MassHealth Adult Day Health Primary Care (PCP) Order Form

Policy history

Origination date: 01/01/2026
Review/Approval(s): Technology Assessment Committee: N/A
Utilization Management Committee: 10/21/2025 (origination, approved as written), 09/15/2026 (Aligned with the Adult Day Health Payment Policy; clarified clinical assessment, NaviCare and PACE authorization pathways, transportation, documentation, reauthorization, significant-change, level-change, provider-transfer, nonduplication, and payment-level requirements).

Instructions for Use

Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Fallon Health follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

For plan members enrolled in NaviCare, Fallon Health first follows CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.