



Day Habilitation Clinical Coverage Criteria

Description

Day Habilitation is a structured, community-based service for members with intellectual or developmental disabilities who require support to acquire, maintain, or improve self-help, social, adaptive, motor, communication, behavioral, or independent-living skills. Services may include nursing oversight, development skills training, therapy, behavioral support, and ADL assistance.

RELEVANT DEFINITIONS

Day Habilitation Service Plan (DHSP)- A written care plan developed for each member that includes realistic, measurable goals. It prescribes a customized set of activities and therapies aimed at improving or maintaining the member's physical, cognitive, emotional, and occupational capabilities.

Developmental Disability (DD)- A severe, chronic condition, other than mental illness, that begins before age 22, is expected to continue indefinitely, and results in substantial limitations in at least three major areas of functioning, such as self-care, communication, learning, mobility, self-direction, or independent living.

Intellectual Disability (ID)- A condition marked by significant limitations in intellectual functioning and adaptive behavior, affecting conceptual, social, and practical skills. It must originate before age 22 and align with the standards set by the American Association on Intellectual and Developmental Disabilities.

Leveling Tool- An assessment instrument used to determine the appropriate level of day habilitation services for a member. It evaluates the intensity of support needed to help the member acquire, maintain, or improve functional skills. Fallon Health uses this tool to assign service levels (Level 1 through Level 4) and determine reimbursement rates.

Service Needs Assessment (SNA)- A detailed evaluation conducted by the IDT's clinical members to determine the member's functional abilities, strengths, and areas of need. It guides the development of the DHSP and is updated every two years or upon a significant change in the member's condition.

Significant Change- A major change in the member's medical, behavioral, cognitive, functional, or support needs that may affect the member's Day Habilitation Service Plan, level of service, or eligibility and requires review by the interdisciplinary team and reassessment, as appropriate.

Policy

This Policy applies to the following Fallon Health products:

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

Authorization Requirements

- Prior authorization is required before services begin and before the current authorization expires.
- Authorization may be approved for up to two years based on medical necessity and the assessed service level.
- Updated assessment and authorization documentation are required upon significant change or level change.
- For a provider transfer, the new provider must submit a current SNA and Day Habilitation Leveling Tool and obtain authorization before billing.
- For NaviCare members, effective January 1, 2027, the Day Habilitation provider must submit complete requests directly to Fallon Health.
- For PACE participants, services must be authorized and coordinated by the PACE interdisciplinary team.

Fallon Health Clinical Coverage Criteria

Clinical Coverage Criteria

Day Habilitation is medically necessary when:

- the member has a documented intellectual or developmental disability;
- the member requires Day Habilitation to acquire, maintain, or improve functional skills or independence;
- the SNA, Leveling Tool, DHSP, and supporting clinical records establish the appropriate service level;
- services are coordinated with other programs and do not duplicate another covered service; and
- any additional requirements applicable to nursing-facility residence are met.
- Hospice Enrollment: For members receiving hospice services, documentation must demonstrate coordination of services and that requested Day Habilitation services are not duplicative of services covered by hospice.

Level of Need Determination:

- Fallon Health will determine the appropriate service level based on:
 - The member's medical and behavioral health needs.
 - The Service Needs Assessment (SNA).
 - A completed Day Habilitation Leveling Tool.
 - For a member residing in a nursing facility, the applicable Level II PASRR documentation.

Required Documentation

- Completed authorization request and PCP order.
- Clinical documentation supporting the intellectual or developmental disability.
- Current SNA, Day Habilitation Leveling Tool, and DHSP.
- Applicable behavior, therapy, nursing, or other clinical plans supporting the requested level.
- For nursing-facility residents, required Level II PASRR or other applicable specialized-services documentation.
- For one-to-one nursing requests, documentation of the nursing need, interventions, frequency, duration, and why standard program staffing is insufficient.
- For reauthorization, updated documentation demonstrating continued eligibility, medical necessity, service level, and coordination.

Service Duplication

Requested Day Habilitation services must not duplicate services available through hospice, nursing facility services, vocational programs, educational programs, or other covered services.

Medicare Variation

N/A

MassHealth Variation

N/A

Exclusions

Day Habilitation is not covered for:

- vocational, prevocational, employment, sheltered-workshop, or academic-education services;
- members residing in an ICF/IID;
- services provided without prior authorization;
- canceled sessions or undocumented absences;
- services furnished during an inpatient stay, except as permitted on admission or discharge dates;
- services that duplicate hospice, nursing-facility, vocational, educational, or other covered services; or
- services that the program cannot safely or appropriately furnish.

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-U1	Day care services, adult, per diem (day habilitation, community based, Level 1)
S5102-U2	Day care services, adult, per diem, intermediate level of care (day habilitation, community based, Level 2)
S5102-U3	Day care services, adult, per diem, complex/high tech level of care (day habilitation, community based, Level 3)
S5102-U4	Day care services, adult, per diem, complex/high tech level of care (day habilitation, community based or nursing facility resident, Level 4)
S5101-U1	Day care services, adult, <i>half per diem</i> (day habilitation, community based, Level 1)
S5101-U2	Day care services, adult, <i>half per diem</i> , intermediate level of care (day habilitation, community based, Level 2)

S5101-U3	Day care services, adult, <i>half per diem</i> , complex/high tech level of care (day habilitation, community based, Level 3)
S5101-U4	Day care services, adult, <i>half per diem</i> , complex/high tech level of care (day habilitation, community based or nursing facility resident, Level 4)
S5100-U1	Day care services, adult, quarter per diem (day habilitation, community based, Level 1)
S5100-U2	Day care services, adult, quarter per diem, intermediate level of care (day habilitation, Level 2)
S5100-U3	Day care services, adult, quarter per diem, complex/high tech level of care (day habilitation, community based, Level 3)
S5100-U4	Day care services, adult, quarter per diem, complex/high tech level of care (day habilitation, community based or nursing facility resident, Level 4)
T2003	Nonemergency transportation; non-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.)
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.)
T2003-U7	Nonemergency transportation; monitor 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. MassHealth Day Habilitation Regulations. Accessed October 20, 2025. <https://www.mass.gov/doc/day-habilitation-dh-regulations-3/download>
2. Executive Office of Health and Human Services (EOHHS): 130 CMR 419.00 Mass Health Day Habilitation Provider Manual. Accessed October 20, 2025. <https://www.mass.gov/doc/day-habilitation-dh-regulations-3/download>
3. Executive Office of Health and Human Services (EOHHS): 101 CMR 348.00 Rates for Day Habilitation Services. Accessed October 20, 2025. <https://www.mass.gov/doc/101-cmr-348-rates-for-day-habilitation-services/download>
4. Mass Health Guidelines for Medical Necessity Determination for Day Habilitation. Accessed October 20, 2025. <https://www.mass.gov/doc/guidelines-for-medical-necessity-determination-for-day-habilitation-0/download>

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 Day Habilitation Payment Policy; clarified NaviCare and PACE authorization pathways, authorization types, documentation, provider transfer, reauthorization, nonduplication, and coding 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.