Day Habilitation Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

☐ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☐ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO (Medicaid-only)
☒ Summit Eldercare PACE
☐ Fallon Health Weinberg PACE
☐ Community Care (Commercial/Exchange)

Policy

Day Habilitation (DH) is a service for individuals with an intellectual disability (ID) or a developmental disability (DD) that is based on a day habilitation service plan (DHSP) that sets forth measurable goals and objectives, and prescribes an integrated program of activities and therapies necessary to reach the stated goals and objectives as described in MassHealth Program regulations at 130 CMR 419.000.

DH providers may no longer obtain PAs or claim payments for Individualized Staffing Supports (ISS) for dates of service on or after September 1, 2024 (MassHealth Day Habilitation Bulletin 31 August 2024).

A member residing in a nursing facility may receive DH services to improve the member's level of independent functioning. These services may be provided within the nursing facility or the member may be transported to a community-based day habilitation provider.

DH is covered by the Plan for NaviCare HMO SNP, NaviCare SCO members and Summit ElderCare PACE plan members. Prior authorization is required.

Fallon Health (the Plan) determines medical necessity for DH on a case-by-case basis in accordance with 130 CMR 419.406: *Clinical Eligibility Criteria*, and in accordance with 130 CMR 450.204: *Medical Necessity*.

Prior authorization specifies the level of payment for the service. The Leveling Tool determines the member's qualifying needs while at DH, measured by the level of supports needed for the member to acquire, improve, or retain maximum skill level and independent functioning. The DH Leveling Tool and instructions for its completion can be found on the **LTSS Provider Portal**.

(1) Level 1. The MassHealth agency pays the Payment Level 1 rate to DH providers for each date of service billed for a clinically eligible member whose Leveling Tool score identifies them as Level 1.

(2) Level 2. The MassHealth agency pays the Payment Level 2 rate to DH providers for each date of service billed for a clinically eligible member whose Leveling Tool score identifies them as Level 2.

(3) Level 3. The MassHealth agency pays the Payment Level 3 rate to DH providers for each date of service billed for a clinically eligible member whose Leveling Tool score identifies them as Level 3.

(4) Level 4. The MassHealth agency pays the Payment Level 4 rate to DH providers for each date of service billed for a clinically eligible member whose Leveling Tool score identifies them as Level 4. Members who live in an NF and have a Level II PASRR will qualify as Level 4. Members whose SNA demonstrates a need for six hours a day of nursing will be in Level 4 if the nursing services are delivered by the DH; additional documentation regarding nursing duties will be required.

(5) Leveling Adjustment. The skilled service needs related to nursing, performed by a continuous skilled nurse contracted to provide services to an individual member in a one-to-one capacity throughout the entire day, are not considered qualifying DH needs for the purpose of the Leveling Tool.

MassHealth has **Guidelines for Medical Necessity Determination for Day Habilitation**. These Guidelines identify the clinical information that MassHealth uses to establish medical necessity of prior authorization requests for DH and DH ISS.

Summit ElderCare PACE

Each Summit ElderCare PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as approved 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 approved by the interdisciplinary team.

Clinical Eligibility Criteria

(A) All members, except those who are residents of a nursing facility, must meet the following clinical eligibility criteria for receipt of DH:

(1) have ID or DD as defined in 130 CMR 419.402 and as certified by a PCP; and
(2) need DH to acquire, improve, or retain their maximum skill level and independent functioning.

(B) In order for a plan member residing in an NF to be eligible for receipt of DH, the Massachusetts Department of Developmental Services (DDS) must have determined via a Level II PASRR that the member requires specialized services.

(C) In order for a plan member receiving hospice services to be eligible for receipt of DH, the DH provider must obtain in writing from the member's hospice provider that the DH is not providing services related to the member's terminal illness, and that the DH services to be provided are not equivalent to or duplicative of hospice services.

Scope of Day Habilitation

A DH provider must provide the following services:

(1) Nursing Services and Health Care Supervision. The DH provider must provide nursing coverage on site. Nursing services must be provided to meet the needs of each member and must include the following:

(a) administration of medications and treatments prescribed by the member's PCP during the time the member is at the program;
(b) education in hygiene and health concerns;
(c) coordination of each member's DHSP with other health care professionals including the NF where the member resides, if applicable;
(d) monitoring each member's health status and documenting those findings in the member's medical record at least quarterly, or more often if the member's condition requires more frequent monitoring. Nursing must also document any findings every six months as part of the interdisciplinary team's semi-annual review;
(e) reporting changes in the member's condition to the member's PCP;
(f) oversight of the implementation of the IDT recommendations, therapy treatment as recommended by a licensed therapist and, as applicable, PCP order; and
(g) coordinated implementation of the PCP's orders with the member, authorized representative, and DH provider staff.

(2) Developmental Skills Training. The DH provider must provide skills training in the following areas: self-help development, sensorimotor development, communication development, social development, independent living development, affective development skills, behavior development, and wellness.

(3) Therapy Services. The DH provider must provide therapy services when recommended by the SNA. Therapy services include

(a) speech/language therapy;

(b) occupational therapy;
(c) physical therapy; and
(d) behavior management.

(4) Assistance with Activities of Daily Living (ADL). The DH provider must have sufficient staff at its site to provide assistance with ADLs to members as necessary.

(5) Day Habilitation Service Management. The DH provider must undertake activities that ensure implementation of the member's day habilitation service plan including required reviews described in 130 CMR 419.419(C).

Transportation Services

Transportation service provides for transporting members from the member's home to the DH provider (for the provision of DH services) or from the DH provider to the member's home, including assisting the member while entering and exiting the vehicle, as appropriate. For the purposes of this section, a home includes any residential service locations, as well as private dwellings.

DH providers may provide transportation service as defined at 130 CMR 419.411(A) either directly or through a subcontractor.

The transportation plan must be documented in the member's record.

The DH provider must ensure that all transportation provided by the DH program or its subcontractor meets criteria in 130 CMR 419.411(D), (E) and (F).

Service Needs Assessment and Day Habilitation Leveling Tool

(A) Service Needs Assessment. A Service Needs Assessment (SNA) is completed by the clinical members of the IDT and determines a member's functional level, needs, and strengths, and makes specific recommendations to address acquisition, improvement, or maintenance of each identified need area for the member. Each SNA must:
(1) be completed within 45 business days of a member's admission and every two years thereafter and upon a significant change in the member's condition;
(2) assess each of the following need areas: self-help skills, sensorimotor skills, communication skills, independent living skills, affective development skills, social development skills, behavioral development skills, and wellness; and
(3) identify which need areas will be addressed in the DHSP.
(4) Assessment Criteria. Providers must include the following as part of the initial assessment or reassessment of a member:
(a) confirmation that the member had a physical examination or wellness visit by a PCP within 12 months before the start of DH services; and
(b) a certification, signed by a PCP, supporting the diagnosis of ID or DD.

(B) Leveling Tool. Using the results of the SNA, a DH provider must identify the member's appropriate DH service level and acquire Prior Authorization (PA). The Leveling Tool will identify the member as Level 1, Level 2, Level 3, or Level 4. A new Leveling Tool is required, along with a new SNA, every two years or sooner if the member experiences a significant change.

The DH Leveling Tool and instructions for its completion can be found on the **LTSS Provider Portal**.

Day Habilitation Service Plan (DHSP)

(A) Interim DHSP - Within five business days after the member's admission, the DH provider's professional interdisciplinary team must design an interim DHSP. The plan must outline a temporary schedule of treatment and activities that will be used until the final DHSP is completed.

(B) Final DHSP - Together with the SNA, the final DHSP must be completed within 45 business days from the date of the member's admission and updated every two years and upon significant change and must be developed with participation of the member, the member's authorized representatives, where applicable and appropriate, and must be derived from the SNA for each member. The final DHSP describes each training program, measurable goals,

and objectives that address the need areas identified in the SNA. The DHSP must be designed in a manner that integrates the various activities, tasks, and, if appropriate, therapies recommended to meet the member's areas of need. The final DHSP must include, but is not limited to, the following:
(1) a medical plan of care;
(2) a service plan coversheet that outlines the development of the member's DHSP, based on the recommendations from the SNA; and
(3) goals and objectives that are written in measurable terms.
(a) Each goal must
1. be written without the use of ambiguous action verbs;
2. be member-driven; and
3. provide clear means for attaining the goal within an established time frame.
(b) Objectives must address specific skill acquisition and retention as it relates to a goal and must
1. be written without the use of ambiguous action verbs;
2. be member-driven;
3. measure only one behavior; and
4. identify measurable outcomes performance and stability criterion.

(C) Reviews

(1) The DHSM must review the member's goals and objectives every six months or upon significant change and must inform the staff, using staff meetings, of any changes in the member's status or DHSP.
(2) The DHSM must ensure that monthly progress notes related to the member's DHSP are completed by staff and reflect the member's plan of care. Any significant changes in the member's health status must be discussed with the DH staff.
(3) The interdisciplinary team must, at least two times per year, conduct a semi-annual review to address the member's overall progress. Components of this review, at a minimum, must include
(a) a comprehensive review of the member's goals and objectives (if a change in goals and objectives is indicated by the review, the member's DHSP must be updated); and
(b) comprehensive medical review based on the member's DHSP.

Discharge

The DH provider must coordinate the discharge with the member, member's authorized representative, DDS, if applicable, and with the staff of the DH provider or other agency to which the member is being transferred, if applicable.

A discharge plan, dated and signed by the program director, must be kept in the member's record for at least six years after the date of discharge and must remain accessible to representatives from the Plan, MassHealth and other state and federal agencies that are authorized by law to have such information.

Day Habilitation for Plan Members with ID/DD Residing in Nursing Facilities

For purposes of providing DH to members with ID or DD who are residing in NFs, DH providers must comply with all of the requirements outlined in 130 CMR 419.433 as well as coordinate and communicate with the member, the DDS service coordinator, if applicable, and the NF, actively participate in the development of the RISP, and attend the NF plan of care meetings to ensure that the DHSP complements and reinforces the service plans referenced in the member's RISP.

(A) Admission Criteria - In addition to the criteria outlined in 130 CMR 419.406, a member with ID or DD residing in a nursing facility (NF) may receive DH designed to improve the member's level of independent functioning.

(B) Service Needs Assessment (SNA) - In addition to the requirements outlined in 130 CMR 419.407, the SNA for a MassHealth member with ID or DD who is residing in a NF and who receives DH must

(1) be completed by a qualified professional who must possess a master's degree in a humanservices-related field or other professional license in a human or health services field;
(2) include any and all applicable therapy or nursing assessments completed by the NF. In lieu of utilizing assessments completed by the NF, the provider may complete specialized assessments that take into consideration the member's disabilities;
(3) assess all specialized service need areas to determine if specialized services are needed and if so, what DH services are appropriate to meet those needs; and
(4) be completed upon a significant change involving a change in the member's Level II PASRR or as the member's RISP dictates.

(C) Day Habilitation Service Plan (DHSP) -
(1) The comprehensive DHSP must meet all of the requirements set forth in 130 CMR 419.416 and must:
(a) be completed and forwarded to the DDS service coordinator if applicable, together with the SNA, within 90 days of the referral for specialized services;
(b) be completed in conjunction with the DDS service coordinator as applicable, and the NF;
(c) provide DH that is adequate in frequency and intensity to lead to progress; and
(d) ensure, in conjunction with the NF, that the DHSP interventions complement and reinforce the RISP.
(2) DH contained in the DHSP must be available and offered to the member.
(3) To ensure progress toward goals and objectives and to identify significant changes, the DHSP should be evaluated on the following schedule.
(a) Monthly Reviews. In addition to the requirements outlined in 130 CMR 419.419, the DHSM must notify the member's DDS service coordinator within seven business days if the monthly review demonstrates a significant change in the member's condition that may affect the Level II PASRR determinations, if applicable.
(b) Quarterly Reviews. The quarterly review must
1. include a reevaluation of continued need for in-facility DH; and
2. be conducted with the DDS service coordinator in conjunction with the NF quarterly plan of care meeting, when applicable.

(D) Communication and Coordination Requirements - For each NF resident with ID or DD that receives DH, the DH provider staff must:
(1) meet with the NF at least twice each year, in addition to the annual plan of care meeting, to coordinate the development and update of the DHSP;
(2) provide copies of the interim DHSP to the members of the RISP interdisciplinary team at least three days prior to the initial RISP meeting;
(3) submit the final DHSP, and any changes to the plan, for approval by the RISP interdisciplinary team;
(4) incorporate any changes recommended by the RISP interdisciplinary team into the final DHSP within 45 days of the initial RISP meeting;
(5) determine what other care plans have been, or are in the process of being developed by other providers or agencies in an effort to avoid duplication;
(6) ensure that the goals and objectives of the DHSP are consistent with those in the other plans and forward a copy to the DDS area office, and the NF; and
(7) immediately notify the DDS service coordinator, where applicable, in the event of a disruption of DH.

(E) Ongoing Documentation and Recordkeeping Requirements -
(1) DH Providers - In addition to the requirements outlined at 130 CMR 419.416, DH providers must develop and maintain records that document the DH provided to members with ID or DD residing in an NF. Such documentation must include
(a) the date the member was referred for specialized services in a DH setting; and
(b) documentation that the RISP interdisciplinary team has approved the final DHSP and any subsequent plan revisions.
(2) Nursing Facilities - The DH provider must:
(a) provide to the NF copies of the DHSP and any revisions to it, the SNA, and quarterly progress notes;

(b) attend the annual NF plan of care meeting at the NF to coordinate the development of the two plans; and
(c) accommodate requests from NFs to carry-over the strategies employed in the provision of DH to a member.

(3) DDS Service Coordinators - DH providers must communicate with DDS service coordinators as follows:
(a) contact the DDS service coordinator for instruction in the event that the DH provider determines that it is not appropriate to provide DH to a member in the specialized services need areas;
(b) communicate with the DDS service coordinator concerning all issues related to DH, including notification of any changes in the DHSP goals, objectives and/or strategies; and
(c) forward a copy of the DHSP and quarterly reviews to the DDS service coordinator for inclusion in the RISP at the NF.

(F) Provision of DH in an NF (In-facility) - DH may be provided in the NF to a member with ID or DD when:
(1) the member is so medically fragile that transport to a DH provider site outside of the NF presents a significant risk to the health and safety of the member;
(2) the member has declined to receive DH at the DH provider's community site; or
(3) as determined by the RISP interdisciplinary team, DH is the only service that is available to meet the member's specialized services needs.

Definitions

The following terms are used in 130 CMR 419.000:

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

Day Habilitation (DH) – A service, for individuals with an intellectual disability (ID) or a developmental disability (DD), that is based on a day habilitation service plan that sets forth measurable goals and objectives, and prescribes an integrated program of activities and therapies necessary to reach the stated goals and objectives.

Day Habilitation Provider (DH Provider) – The entity with responsibility for the day-to-day operation of services and programs subject to 130 CMR 419.000.

Day Habilitation Service Plan (DHSP) – A written plan of care for each member that sets forth realistic and measurable member-driven goals that prescribe an integrated program of individually designed activities and/or therapies necessary to achieve these goals. The objective of the plan is to help the member reach his or her optimal level of physical, cognitive, psychosocial, occupational capabilities, and wellness.

Department of Developmental Services (DDS) – an agency of the Commonwealth of Massachusetts established under M.G.L. c. 19B.

Developmental Disability – a severe, chronic disability that (1) is attributable to other conditions found to be closely related to ID, apart from mental illness, which results in the impairment of general intellectual functioning or adaptive behavior similar to that of persons with ID, and which requires treatment or services similar to those required for such persons; (2) is manifested before a person reaches 22 years of age; (3) is likely to continue indefinitely; and (4) results in substantial functional limitations in three or more of the following major areas: (a) self-care; (b) understanding and use of language; (c) learning; (d) mobility; (e) self-direction; or (f) capacity for independent living.

Instrumental Activities of Daily Living (IADLs) – Activities related to independent living that are incidental to the care of the member and that include, but are not limited to, household-management tasks, laundry, shopping, housekeeping, meal preparation and cleanup, transportation, care and maintenance of medical equipment and adaptive devices, medication management or any other need determined by the DH provider as being instrumental to the health care and general well-being of the member.

Intellectual Disability (ID) – A disability characterized by significant limitations in both intellectual functioning and adaptive behavior as expressed in conceptual, social, and practical skills and that originates before the individual attains age 22. The meaning of ID is consistent with the standard contained in the 12th edition of the American Association on Intellectual and Developmental Disabilities' Intellectual Disability: Definition, Classification, and Systems of Supports (2021) or any subsequent publication.

Interdisciplinary Team (IDT) – The team consists of the Registered Nurse (RN)/health care supervisor, developmental specialist, DHSM, and program director. The IDT must also include the following clinical members: a physical therapist, speech and language pathologist, occupational therapist, and behavioral professional. Other health care professionals may be included, as applicable. See additional information on IDT under MassHealth regulation 419.421(B).

Resident Integrated Service Plan (RISP) – A comprehensive service plan developed by an interdisciplinary team consisting of the DDS service coordinator where applicable, the member (or authorized representative), NF staff representatives, the specialized services provider, and other relevant professionals (such as physical therapists, speech pathologists, occupational therapists, dieticians, and medical staff). The purpose is to address care in all settings for persons with ID or DD who reside in NFs and receive specialized services.

Service Needs Assessment (SNA) – A compilation of evaluations by the clinical members of the IDT (Registered Nurse, OT, PT, SLP, Behavior Professional). The SNA determines a member's level of functioning, needs, and strengths, and makes specific recommendations for DH to address identified needs.

Transportation – The method by which a member is brought from their home to the day habilitation provider or from the day habilitation provider to the member's home. Transportation service includes assisting the member while they enter and exit the vehicle, as appropriate.

Reimbursement

The Plan reimburses contracted DH providers for DH services provided from the first date on which services are authorized through PA.

DH providers may no longer obtain PAs or claim payments for Individualized Staffing Supports (ISS) for dates of service on or after September 1, 2024 (MassHealth Day Habilitation Bulletin 31 August 2024).

Conditions of Payment

The Plan will reimburse a DH provider for DH only if:

(1) the member receiving DH is eligible under MassHealth regulations at 130 CMR 419.403;

(2) the member meets the clinical eligibility criteria for DH in accordance with MassHealth regulations at 130 CMR 419.406;

(3) the DH provider has obtained prior authorization for DH in accordance with MassHealth regulations at 130 CMR 419.407;

(4) the DH provider is not billing for days that are non-covered under 130 CMR 419.431; and

(5) for members who reside in an NF, the member's Level II PASRR conducted by DDS determines that the member requires specialized services.

The Plan's payment to a DH provider ends on the date on which a member no longer meets the clinical criteria for DH described in 130 CMR 419.406 or is no longer receiving DH, whichever comes first. A DH provider may not bill and the Plan will not pay for any member who does not meet the clinical criteria for DH.

Day Habilitation Provider Responsibilities

The DH provider must must meet all requirements in MassHealth regulations at 419.416, including but not limited to the development and maintenance of policies and procedures governing the delivery of DH, maintenance of member records, administrative records and staffing requirements.

Day Habilitation Staff Qualifications, Responsibilities, and Training

The DH provider must must meet all staff qualifications, responsibilities, and training requirements in MassHealth requlations at 419.421.

Emergency Services and Plans

The DH provider must establish plans, policies, and procedures for medical and other emergencies in accordance with MassHealth regulations at 419.430.

Physical Site

The MassHealth agency or its designee approves each DH site and census. A DH provider must provide DH at a site that meets all of the requirements in 130 CMR 419.432(B)(1) through (17).

Rate Provisions

For services provided in day habilitation programs in the community, the contract/fee schedule rates include payment for all care and services that are customarily part of the program of services of an eligible provider, subject only to the terms of the agreement between the eligible provider and the Plan. The rate of payment for authorized services is the lower of the billed charge or contract/fee schedule rate.

Day Habilitation Services in Nursing Facilities – Certain residents of nursing facilities who qualify for DH services may be unable to participate in these services in community settings. These individuals may qualify for DH services to be provided at the nursing facility in which they reside. In order to be eligible for these nursing facility services, the individual must meet criteria established by MassHealth regulations at 130 CMR 419.433. These members will be billed at the Level 4 rate. The approved rates cover all care and services associated with the provision of DH services in a nursing facility.

Day Habilitation Services for Nursing Facility Residents Participating in Community Day Habilitation Programs – Certain qualifying individuals in nursing facilities may need supplemental services in the form of additional staff assistance to enable them to leave their nursing facility to participate in day habilitation services in the community. The Plan will pay the Level 4 rate for those individuals so they may participate in a community day habilitation program.

Noncoverage

The following are considered non-covered days and are ineligible for payment under 130 CMR 419.000:

(A) Any portion of a day outside the approved rate structure described in 101 CMR 348.00: Rates for Day Habilitation Services, during which the member is not receiving scheduled services from the DH provider, unless the provider documents that the member was receiving services from the DH provider's staff in a community setting.
(B) DH provided to a member when the member's needs can no longer be met by the DH as determined by the PCP and the professional interdisciplinary team in consultation, or by a qualified representative of the MassHealth agency, DDS, or DPH.
(C) Days or portion(s) of a day outside of the rate structure in 101 CMR 348.00: Rates for Day Habilitation Services on which the following services are provided:
    (1) vocational- and prevocational-training services, which include vocational-skills assessment, career counseling, job training, and job placement;
    (2) work-related services, which provide participants with work skills and supervised employment for the production of saleable goods;
    (3) educational services, which involve traditional classroom instruction of academic subjects, tutoring, and academic counseling; and
    (4) social, vocational, and recreational services not administered through the DH provider.
(D) DH provided to members residing in an intermediate care facility (ICF) for individuals with ID.
(E) DH provided more than five days per week and six hours per day per member;
(F) DH provided at a site that has not been approved by the MassHealth agency or its designee or does not have a current approval on file;
(G) DH provided on or after the effective date of the discharge plan; and

(H) Claims billed above the census on file as approved by the MassHealth agency or its designee.

Referral/notification/prior authorization requirements

Prior authorization (PA) is required for DH.

- Requests for prior authorization must be submitted to the NaviCare Clinical Team for NaviCare members.
- Requests for prior authorization for Summit ElderCare PACE members must be submitted to the member's interdisciplinary team at Summit ElderCare PACE.

DH providers may no longer obtain PAs or claim payments for ISS for dates of service on or after September 1, 2024 (MassHealth Day Habilitation Bulletin 31 August 2024).

The DH provider must obtain PA from the Plan as a prerequisite to payment for the provision of DH upon admission, every two years thereafter, and upon significant change.

PA determines the medical necessity for DH as described under 130 CMR 419.406: *Clinical Eligibility Criteria* and 130 CMR 450.204: *Medical Necessity*.

For dates of service on or after September 1, 2024, the new DH Leveling Tool must be used to obtain PA authorizing a DH provider to claim for service provided to an eligible member at one of the four levels of payment reflecting the member's assessed need for DH.

The new DH Leveling Tool and instructions for its completion can be found on the **LTSS Provider Portal**.

A day habilitation member is rated as Level 1, Level 2, Level 3, or Level 4 based on their score on the Day Habilitation Leveling Tool:
(A) Level 1 Member—scores between 0 and 22.
(B) Level 2 Member—scores between 23 and 44.
(C) Level 3 Member—scores between 45 and 61
(D) Level 4 Member—scores 62 or higher

When submitting a request for PA for members living in an NF, the DH provider must submit the Level II PASRR.

When submitting a request for PA for members who demonstrate medical necessity for one-to-one nursing for all six program hours, the DH provider must provide additional documentation in the form and format designated by MassHealth.

Transferring From One DH Provider to Another
If a member changes from one DH provider to another DH provider, a new SNA and DH Leveling Tool is required and the new DH provider must obtain a new PA. The previous DH provider must discharge the member from its DH program before the new DH provider may bill the Plan for DH. The Plan will pay only one DH provider per day for the provision of DH to a member.

Summit ElderCare PACE
Each Summit ElderCare PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as approved 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 approved by the interdisciplinary team.

Billing/coding guidelines

DH providers may no longer obtain PAs or claim payments for Individualized Staffing Supports (ISS) for dates of service on or after September 1, 2024.

Consistent with the guidance in Day Habilitation Bulletin 30, the new DH Leveling Tool must be used when submitting for PA on or after September 1, 2024. The DH Leveling Tool will identify the member as Level 1, Level 2, Level 3, or Level 4.

The DH Leveling Tool and instructions for its completion can be found on the **LTSS Provider Portal**.

A day habilitation member is rated as Level 1, Level 2, Level 3, or Level 4 based on their score on the Day Habilitation Leveling Tool:
(A) Level 1 Member—scores between 0 and 22.
(B) Level 2 Member—scores between 23 and 44.
(C) Level 3 Member—scores between 45 and 61
(D) Level 4 Member—scores 62 or higher

Elimination of Span Date Billing

Effective for dates of service on or after March 1, 2024, DH providers must bill for DH services using one claim line for each date of service. Any claim for DH services, provided on or after this effective date, that includes span date billing will be denied (MassHealth Day Habilitation Bulletin 29 January 2024).

DH Codes and Modifiers

Effective for dates of service on or after August 1, 2024, DH providers must bill for DH services using the code and modifier combinations as described in Subchapter 6 of the Day Habilitation Manual (MassHealth Day Habilititation Bulletin 33 October 2024).

Note: The one-time payments for Day Habilitation Admission Services (S5105) and Re-engagement Services (S5105 KZ) pursuant to 101 CMR 348.00 are excluded from the Plan's coverage of Day Habilitation; claims for such services shall be paid directly by MassHealth effective for dates of service on or after July 5, 2023.

Codes S5102, S5101, and S5100 (including use with all modifiers) are billable in per diem, half per diem, and quarter per diem units. The maximum allowable unit(s) for day habilitation services is one unit per claim date of service. The per diem unit must be used for service greater than three hours per day. The half per diem unit is used for service between 1.5 hours and three hours per day, and the quarter per diem is used for service under 1.5 hours per day. The maximum allowable units apply to day habilitation service codes only. See Service Code T2003 for minimum/maximum units allowed for in-facility transportation services.

- Per Diem. Day habilitation services provided for a period greater than three hours per day.
- Half Per Diem. Day habilitation services provided for a period equal to or less than three hours per day.
- Quarter Per Diem. Day habilitation services provided for a period equal to or less than one and a half hours per day.

Code T2003 (including use with all modifiers), which is effective January 19, 2024, is denoted for nonemergency transportation, defined as the method by which a member is brought from their home to the day habilitation provider or from the day habilitation provider to the member's home. Transportation service includes assisting the member while they enter and exit the vehicle, as appropriate. A member's home may include a temporary housing environment such as a shelter or transitional housing.

Code	Description
S5102-U1	Day care services, adult, *per diem* (day habilitation, community based, Level 1)
S5102-U1	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)

Code	**Description**
S5101-U1	Day care services, adult, *half per diem* (day habilitation, community based, Level 1)

S5101-U2	Day care services, adult, *half per diem*, intermediate level of care (day habilitation, community based, Level 2)
S5101-U3	Day care services, adult, *half per diem*, complex/high tech level of care (day habilitation, community based, Level 3)
S5104-U4	Day care services, adult, *half per diem*, complex/high tech level of care (day habilitation, community based or nursing facility resident, Level 4)

Code	Description
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)

Code	Description
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.)

Place of service (POS)

This policy applies to DH services provided in DH programs in the community and in a nursing facility.

Policy history

Origination date:	03/01/2023
Connection date & details:	January 2023 – Policy origination. October 2024 – Updated policy clarifying the following: The one-time payments for Day Habilitation (DH) Admission Services (S5105) and Re-engagement Services (S5105 KZ) that are effective July 5, 2023 are excluded from the Plan's coverage of DH; claims for such services shall be paid directly by MassHealth. Effective August 1, 2024, DH providers must bill for DH services using the code and modifier combinations as described in Subchapter 6 of the Day Habilitation Manual (MassHealth Day Habilititation Bulletin 33 October 2024). The new DH Leveling Tool must be used when submitting requests for PA on or after September 1, 2024. The new DH Leveling Tool will identify the member as Level 1, Level 2, Level 3, or Level 4. DH providers may no longer obtain prior authorizations or claim payments for Individualized Staffing Supports (ISS) for dates of service on or after September 1, 2024.

The criteria listed above apply to Fallon Health Plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.