Day Habilitation Payment Policy

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.

Certain members may need supplemental services in the form of additional one-to-one staff assistance in order to participate in a DH program. These one-to-one services are referred to as "Individualized Staffing Supports" (ISS).

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.

Fallon Health (the Plan) determines medical necessity for DH and DH ISS on a case-by-case basis in accordance with 130 CMR 419.00. The prior authorization process will identify the member's service level as Low-Need, Moderate-Need, High-Need and if applicable, ISS. If the member requires ISS, the Plan will also determine the total units of ISS the member requires in order to participate in DH services.

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

Effective for dates of service on or after October 1, 2022, DH ISS is covered for eligible NaviCare HMO SNP, NaviCare SCO and Summit ElderCare PACE plan members.

MassHealth has **Guidelines for Medical Necessity Determination for Day Habilitation**. These Guidelines for Medical Necessity Determination identify the clinical information that MassHealth uses to establish medical necessity of prior authorization requests for DH and DH ISS. The Plan will follow the MassHealth Guidelines when making medical necessity determinations for DH and DH ISS for NaviCare plan members.

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.

Eligible Members (per MassHealth regulations at 130 CMR 419.406)

(A) All eligible 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. In addition, a plan member with ID or DD residing in a NF may receive DH designed to improve the member's level of independent functioning. For purposes of providing DH to plan 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.

(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 (per MassHealth regulations at 130 CMR 419.405)

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).

Service Needs Assessment (per MassHealth regulations at 130 CMR 419.407(A))

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.

Day Habilitation Leveling Tool (per MassHealth regulations at 130 CMR 419.407(B))

Using the results of the SNA, a DH provider must identify the member's appropriate DH service level and acquire Prior Authorization (PA). The DH Leveling Tool will identify a member as Low-Need, Moderate-Need, or High-Need. If the SNA and DH Leveling Tool identifies that the member requires one-to-one staffing supports in order to participate in DH services, the DH provider must follow the prior authorization process for ISS. A new DH Leveling Tool is required every two years or sooner if the member experiences a significant change.

(1) Assessment Period. Members newly seeking DH may receive DH for up to 45 business days concurrent with the provider's completion of the member's initial clinical assessment for DH.

(2) 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 prior to the start of DH services; and

(b) a certification, signed by a PCP, supporting the diagnosis of Intellectual Disability (ID) or Developmental Disability (DD).

(3) For members residing in NFs for whom the Level II PASRR conducted by DDS concluded that the member requires specialized services, the DH provider must obtain a copy of the DDS Level II PASRR determination notice and maintain a copy of this notice in the member's record.

Day Habilitation Service Plan (DHSP) (per MassHealth regulations at 130 CMR 419.419)

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.

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.

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 (per MassHealth regulations at 419.420)

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 (per MassHealth regulations at 130 CMR 419.433)

(A) Admission Criteria - In addition to the criteria outlined in 130 CMR 419.406, a plan 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 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.

Individualized Staffing Supports (ISS) – one-to-one staff supports provided to a member to enable the member to participate in a DH; this includes direct care and nursing. The Plan determines medical necessity through a prior authorization process which identifies the total units of one-to-one services the member requires to participate in DH. Individualized staffing supports must not be used to enhance general staffing in a DH program.

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.

Reimbursement

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

The Plan will reimburse DH and DH ISS authorized on an interim basis, for up to 60 days following a member's admission to DH. Any DH or DH ISS services provided following the interim authorization must be authorized by the Plan.

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.

Conditions of Payment (per MassHealth regulations at 130 CMR 419.409)

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 and DH ISS, if applicable, 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.

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.

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. Payment for in-facility DH covers all care and services associated with the provision of DH services in a nursing facility. ISS is not covered for members who are residents of nursing facilities.

(a) Serving One, Two, or Three Individuals in a Nursing Facility. In situations where no more than three residents receive day habilitation services in the nursing facility, the rates do not vary by client need. The rates of payment for authorized services, including transportation, must be the lower of the established charge or the rate listed in 101 CMR 348.03(5).

(b) Serving Four or More Individuals in a Nursing Facility. For a staffing level of one to four or more, refer to approved community day habilitation program rates, along with the transportation rate listed in 101 CMR 348.03(5). A maximum of two transportation units can be billed for at most one person for any given nursing facility visit, in accordance with purchasers' specifications.

Supplemental Staffing for Nursing Facility Residents 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. These services do not apply to nursing facility residents who receive day habilitation services at the nursing facility. The Plan will pay a supplemental rate to augment staffing ratios when an individual needs assistance for all or part of the time that an individual participates in a community day habilitation program and meets criteria established by the MassHealth regulations.

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.

The DH provider must obtain PA from the Plan as a prerequisite to reimbursement for the provision of DH, and if applicable, DH ISS, upon admission, every two years thereafter, upon significant change, and when transferring from one DH provider to another.

DH providers may request an interim PA for DH and DH ISS, if applicable, which may be granted for up to 60 days following a member's admission to DH. This PA type allows the provider an initial assessment period to complete the required SNA and DH Leveling Tool to determine future staffing support needed for the member to fully engage in their DHSP.

DH providers must submit requests for PA for DH and DH ISS in a timely manner or up to 21 days prior to the Interim PA expiration.

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. The Plan will follow the MassHealth Guidelines for Medical Necessity Determination for Day Habilitation when making medical necessity determinations for DH and DH ISS for NaviCare plan members.

- The Plan will determine medical necessity for DH through a PA process that identifies member's service level as Low-Need, Moderate-Need, or High-Need. When submitting a request for PA for DH to the Plan, the DH provider must submit all required information, including, but not limited to, documentation of the completed Service Needs Assessment (SNA) and DH Leveling Tool, and any other additional assessments, documentation, or information that the Plan requests in order to complete the review and determination of PA. The Plan will authorize DH for up to 30 hours per week (up to six hours per day for five days per week).
- The Plan will determine medical necessity for DH ISS through a PA process that considers the member's individualized medical and behavioral health needs identified through the SNA and DH Leveling Tool. If the SNA and DH Leveling Tool identify a need for additional individualized staffing supports (ISS) in order for the member to acquire, improve, or retain their maximum skill level, safety, and independent functioning, a member may qualify for ISS. Generally, only members identified as "high need" are likely to also require ISS. DH ISS is not to be used to enhance general staffing in a DH program, but to provide support to a specific member.

  DH ISS is based on Time To Task (TTT) Tool. The TTT Tool is a fillable form that DH providers complete and submit with a request for ISS PA. The purpose of the TTT Tool is to outline the clinical justification for ISS. The TTT Tool allocates ISS hours for specific tasks. Time estimates are guidelines for determining the amount of 1:1 time required to perform activities of daily living (ADLs), instrumental activities of daily living (IADLS), range of motion (ROM) exercises, and behavioral interventions. The MassHealth DH ISS prior authorization form is available at the **LTSS Provider Portal**:

  Instructions for filling out and submitting the Day Hab (DH) ISS Prior Authorization (PA) Time to Task PDF Form

  Day Hab Individualized Staffing Support (ISS) Prior Authorization Time to Task Tool

  Day Hab Individualized Staffing Support (ISS) Time to Task Tool resource guide

  A PA for DH ISS specifies the type of provider (program staff/LPN/RN) requested for one-to-one care to enable a member's participation in in DH. A PA for DH ISS also specifies the units of DH ISS requested which reflects the member's need for one-to-one staffing. DH ISS is authorized in 15-minute units. The minimum amount of authorized ISS is one hour. The maximum authorized time for ISS will not exceed 30 hours per week (up to six hours per day for five days per week). ISS is not covered for members who are residents of nursing facilities.

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, and for DH ISS if applicable. 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 services must be submitted using the following codes and/or code-modifier combinations, or per contract terms.

A DH member is determined to be “low-need,” “moderate-need,” or “high-need” member based on their score on the DH Leveling Tool

(A) Low-Need Member — scores between one and 41.

(B) Moderate-Need Member — scores between 42 and 71.

(C) High-Need Member — scores 72 or higher

Community-Based Services

Codes S5012, 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 following terms apply to billing for DH services:

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

Providers must bill for the actual units of DH ISS (T1019) delivered to a member in a day. The hours of service do not need to be consistent across the days of the week, provided that it does not exceed the total amount of hours authorized.

Code	Description
S5102	Skills training and development, per diem (community program, low need)
S5102-TF	Skills training and development per diem, intermediate level of care (community program, moderate need)
S5012-TG	Skills training and development, per diem, complex/high tech level of care (community program, high need)
S5102-22	Skills training and development, per diem, unusual procedural service, when the service(s) provided is greater than that usually listed for the listed procedure (supplemental staffing for nursing facility residents in community day habilitation)
S5101	Skills training and development, half per diem (community program, low need)
S5101-TF	Skills training and development, half per diem, intermediate level of care (community program, moderate need)
S5101-TG	Skills training and development, half per diem, complex/high tech level of care (community program, high need)
S5101-22	Skills training and development, half per diem, unusual procedural service, when the service(s) provided is greater than that usually listed for the listed procedure (supplemental staffing for nursing facility residents in community day habilitation)
S5100-U5	Skills training and development, quarter per diem (community program, low need)
S5100-U5-TF	Skills training and development, quarter per diem, intermediate level of care (community program, moderate need)

S5100-U5-TG	Skills training and development, quarter per diem, complex/high tech level of care (community program, high need)
T1019	Individualized Staffing Supports (ISS) - Direct Care/Program Staff, per 15 minutes
T1019-TE	Individualized Staffing Supports (ISS) - Licensed Practical Nurse (LPN), per 15 minutes
T1019-TD	Individualized Staffing Supports (ISS) - Registered Nurse (RN), per 15 minutes
T1019-CG	Interim PA: ISS – Direct care/program staff, per 15 minutes
T1019-TE-CG	Interim PA: ISS – Licensed Practical Nurse (LPN), per 15 minutes
T1019-TD-CG	Interim PA: ISS – Registered Nurse (RN), per 15 minutes

In-Facility Services

For services rendered in the nursing facility, the Plan reimburses for day habilitation services based on the staff to participant ratio.

S5102-U1	Skills training and development, per diem (nursing facility, one to two or one to three staffing level)
S5102-U2	Skills training and development per diem (nursing facility, one to one staffing level)
S5101-U1	Skills training and development, half per diem (nursing facility, one to two or one to three staffing level)
S5101-U2	Skills training and development, half per diem (nursing facility, one to one staffing level)
T2003	Non-emergency transportation: encounter/trip (used only when serving four or more individuals in a nursing facility)

Place of service (POS)

This policy applies to DH services provided in DH programs in the community or in a nursing facility (when member eligibility criteria are met).

Policy history

Origination date: 03/01/2023

Connection date & details: January 2023 – Policy origination

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.