

Adult Day Health Services Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

- ☐ Fallon Medicare Plus
- ☐ MassHealth ACO
- ☒ NaviCare HMO SNP
- ☒ Summit ElderCare PACE
- ☒ Fallon Health Weinberg PACE
- ☐ Community Care

Policy

The Plan covers Adult Day Health Services for NaviCare and PACE (Program of All-Inclusive Care for the Elderly) members.

NaviCare

Adult Day Health (ADH) is a structured, daytime program offered in community settings to individuals who face challenges related to physical health, cognitive function, complex medical conditions, or behavioral health. It is designed to provide clinical oversight, personal care, and therapeutic engagement in a non-residential environment. ADH includes transportation to and from the program site.

All ADH Programs must meet Massachusetts Department of Public Health Licensure of Adult Day Health Programs Regulations 105 CMR 158.000.

The ADH Program must maintain administrative records as outlined in 105 CMR 158.031 and the daily attendance records may be requested by Fallon Health to verify claims submitted for payment. These records must be provided within seven (7) days of request by Fallon Health.

NaviCare members may attend ADH Programs when the ADH Program is:

- Contracted with a Massachusetts Aging Services Access Point (ASAP) agency contracted with Fallon Health – In this case, the ASAP is responsible for reimbursing the ADH Program); or
- Contracted with Fallon Health – In this case, Fallon Health will reimburse the ADH Program.

Adult Day Health Services When a NaviCare Member Elects Hospice

In accordance with MassHealth Adult Day Health Bulletin 37 (May 2023), NaviCare members who elect hospice may also choose to receive ADH services if the ADH services are not related to the member's terminal illness, are not equivalent to or duplicative of hospice services, and are provided in accordance with all the requirements for ADH services, including eligibility criteria.

The ADH provider must coordinate services with the member's hospice provider and obtain signed notification from the hospice provider that the ADH program is not providing services related to the member's terminal illness and that the ADH services to be provided are not equivalent to or duplicative of hospice services. The ADH and hospice providers must both maintain documentation of the coordination of services in the member's record.

PACE: Summit ElderCare and Fallon Health Weinberg

Each PACE participant is supported by a PACE interdisciplinary team that authorizes and coordinates covered and medically necessary services in accordance with the participant's comprehensive plan of care.

PACE participants may receive ADH when the PACE IDT determines that the service is necessary and appropriate and incorporates it into the participant's plan of care.

Reimbursement

NaviCare

As a requisite for payment, the ADH Provider must obtain prior authorization from the Plan prior to delivering any ADH services.

For NaviCare members, effective January 1, 2027, contracted ADH providers must submit complete initial authorization, renewal, reauthorization, extension, significant-change, level-change, and provider-transfer requests directly to Fallon Health before services begin or the current authorization expires.

Initial authorization requests must include Fallon Health's completed prior authorization request form; the requested start date, attendance schedule, and Basic or Complex level of care; a current PCP order; a completed ADH provider clinical assessment signed and dated by the assessing registered nurse; the current ADH plan of care; documentation of qualifying skilled services and ADL needs; supporting clinical evaluations and orders; documentation supporting the requested payment level; and coordination information sufficient to demonstrate that the requested services are not duplicative. When the ASAP process applies, the provider must also submit the applicable ASAP referral, PCP order, and clinical eligibility documentation required by Fallon Health.

The ADH provider is responsible for monitoring authorization effective and end dates and submitting complete reauthorization requests before the current authorization period expires. Reauthorizations must include an updated clinical assessment; the current ADH plan of care and progress toward goals; updated documentation of skilled services, ADL needs, service frequency, nursing oversight, and the requested Basic or Complex level; an updated PCP order when required by Fallon Health or when the existing order no longer reflects the member's needs; relevant changes in clinical, behavioral, or functional status; and documentation confirming coordination and nonduplication with other services.

Prior authorization is required before the first date of service, annually thereafter, and upon significant change, level change, or provider transfer. A new or updated clinical assessment and prior authorization request must support the requested Basic or Complex level of care.

Submission of a request does not extend an existing authorization. Authorization requests must include, at a minimum:

- Fallon Health's standardized prior authorization request form completed by the ADH provider.
- A completed ADH provider clinical assessment, signed and dated by the assessing registered nurse, that supports clinical eligibility and the requested Basic or Complex level of care. For reauthorization, a new or updated clinical assessment is required. A new clinical assessment is required annually and upon significant change.
- A current PCP order identifying the member's diagnoses and the treatments, rehabilitation services, skilled services, and ADL assistance required at the ADH program. For reauthorization, an updated PCP order is required when requested by Fallon Health or when the prior order no longer accurately reflects the member's current clinical or functional needs.
- The current ADH plan of care and, for reauthorization requests, updated documentation supporting continued medical necessity, the requested service level, and any change in functional or behavioral status.

For continuity-of-care requests, the provider must submit documentation of the prior insurer's approval or authorization, when applicable.

Fallon Health may request additional clinical records, evaluations, assessments, or other documentation needed to complete the medical necessity and service-level review.

Services furnished after an authorization expires may not be reimbursed when continued authorization has not been obtained, subject to applicable law, the provider agreement, and Fallon Health requirements.

Prior authorization is not a guarantee of payment. Payment remains subject to member eligibility and coverage on the date of service, service delivery and documentation, authorization terms and service level, correct coding and modifiers, timely filing, coordination of benefits, and applicable provider contract requirements.

The following services are reimbursed:

- ADH at the payment level that has been authorized by the Plan.
 - The Plan pays the Basic Payment Level rate for each date of service billed that the member meets the basic clinical eligibility criteria for ADH and the provider meets at least one of the qualifying needs of the member while the member is in attendance at the ADH program.
 - The Plan pays the Complex Payment Level rate for each date of service billed that the member meets the complex clinical eligibility criteria for ADH and the requirements of 130 CMR 404.414(D)(2) are met.
- ADH transportation services that have been authorized by the Plan. ADH transportation provides for transporting members from the member's home to the ADH provider or from the ADH provider to the member's home, including assisting the member while entering and exiting the vehicle, as appropriate. The transportation plan must be documented in the Participant Enrollment Agreement pursuant to 105 CMR 158.034(D)(5).

The Plan does not reimburse any of the following:

1. Any portion of a day during which the member receives duplicative services from a home health agency or similar provider while attending the ADH program, consistent with applicable MassHealth requirements.
2. When the member is a resident or inpatient of a hospital, nursing facility, or intermediate care facility for the intellectually disabled; except on dates of admission and discharge;
3. When the ADH services have not received prior authorization from the Plan;
4. For any canceled program days or any time periods missed by a member for any reason;
5. For any portion of a day during which the member is absent from the site, unless the program documents that the member was receiving services from the program staff outside of the ADH program in a community setting.
6. For ADH transportation for members on days where the member does not have an ADH service claim for ADH attendance that day.

PACE: Summit Eldercare and Fallon Health Weinberg

The following service is reimbursed:

- ADH that is provided by Plan-contracted providers and has been prior authorized.

Referral/notification/prior authorization requirements

NaviCare members: Prior authorization is required for ADH and for separately reimbursable ADH transportation. Requests must be submitted directly to Fallon Health. Effective January 1, 2027, providers are responsible for monitoring active authorizations and submitting complete renewal, reauthorization, extension, significant-change, level-change, and provider-transfer requests before authorization expiration.

PACE participants, including Summit ElderCare and Fallon Health Weinberg: ADH services must be authorized by the participant's PACE IDT and coordinated through the applicable PACE site.

Prior authorization determines the medical necessity for ADH and also specifies the level of payment for ADH.

Billing/coding guidelines

NaviCare and Summit ElderCare PACE

Claims for ADH services must be submitted at the approved level of care utilizing modifiers as required for the approved level of care.

Only one ADH service may be billed for a member per day.

HCPSC codes S5100 and S5100 TG are not payable effective 7/1/2021.

Elimination of span date billing: Effective for dates of service on or after May 1, 2022, ADH providers must bill for ADH services using one claim line for each date of service (for additional information see MassHealth Adult Day Health Bulletin 33 (May 2022)).

ADH Transportation: All ADH transportation services must be billed as one-way trips; round trips should be billed as two one-way trips. ADH transportation services must be billed with POS 41.

Adult Day Health Admission and Re-engagement Services - One-time payments for Adult Day Health Admission Services (S5105) and Re-engagement Services (S5105 KZ) pursuant to 101 CMR 310.00 are excluded from the Plan's coverage of Adult Day Health. Claims for such services are paid directly by MassHealth in accordance with MassHealth Adult Day Health Bulletin 38 (July 2023).

Code	Modifier	Description
S5101		Day care services, adult; partial per diem (Use for ADH Basic Level of Care up to three hours per day)
S5101	TG	Day care services, adult; partial per diem (Use for ADH Complex Level of Care services up to three hours per day)
S5102		Day care services, adult; per diem (Use for ADH Basic Level of Care services over three hours per day)
S5102	TG	Day care services, adult; per diem (Use for ADH Complex Level of Care services over three hours per day)
T2003		Non-emergency transportation; non-wheelchair transportation; encounter/trip
T2003	U6	Nonemergency transportation; wheelchair transportation; encounter/trip.

Fallon Health Weinberg PACE

Services must be submitted in the following manner, or per contract terms.

Code	Modifier	Description
S5102		Day care services, adult; per diem

Place of service

This policy applies to services rendered in ADH settings.

Policy history

Origination date:	04/01/2015
Previous revision date(s):	07/01/2015 – Introduced policy. 05/01/2016 - Annual review.
Connection date & details:	July 2017 - Updated NaviCare and FHW requirements. October 2018 – Updated NaviCare reimbursement section. April 2020 – Updated Policy, Prior Authorization and Billing and Coding sections related to COVID-19 temporary telehealth coverage. May 2020 – Update Policy and Billing and Coding sections related to COVID-19 temporary retainer payments. July 2020 – Updated termination date of COVID-19 retainer

payments

October 2020 – Updated Policy and Billing and Coding sections related to COVID-19 remote ADH services and 3-hour day attendance.

January 2022 – Updated NaviCare billing and coding guidelines.

July 2026 – Updated reimbursement and billing/coding guidelines; removed telehealth provisions no longer applicable due to the end of the COVID-19 public health emergency).

January 2027 - Aligned the Payment Policy with the Adult Day Health Clinical Coverage Criteria; clarified NaviCare and PACE authorization pathways, provider submission and monitoring responsibilities, documentation, reauthorization, significant-change, level-change, provider-transfer, continuity-of-care, transportation, nonduplication, and payment requirements.

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.