Day Services
Medical Necessity Guidelines

Medical Necessity Guideline (MNG) Title: Day Services		
MNG #: 063	**☒SCO ☒One Care** **☒ MA Medicare Premier** **☒ MA Medicare Value** **☒ RI Medicare Preferred** **☒ RI Medicare Value** **☒ RI Medicare Maximum**	**Prior Authorization Needed?** **☒ Yes (always required)** **☐ Yes (only in certain situations. See this MNG for details)** **☐ No**
Clinical: ☒	**Operational: ☐**	**Informational: ☐**
Benefit Type: **☒ Medicare** **☐ Medicaid**	**Approval Date:** 4/1/2021;	**Effective Date:** 06/19/2021
Last Revised Date:	**Next Annual Review Date:** 4/1/2022;	**Retire Date:**

OVERVIEW:

The Day Services Program is a structured, site-based day program that takes place in a non-residential setting separate from member's private residence or other residential living arrangement for members with congenital or acquired brain injuries. The program provides assistance with the acquisition, retention, or improvement in socialization and adaptive skills. The services include assistance to learn activities of daily living and functional skills, language and communication, interpersonal skills, prevocational skills, socialization skills, and compensatory and cognitive strategies.

DECISION GUIDELINES:

Clinical Coverage Criteria:

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses InterQual Smart Sheets, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists.

Clinical Eligibility:

In order to be eligible for this program, member must meet the following requirements:

- Have an acquired brain injury
- Have a need for acquisition, retention and improvement in socialization and adaptiveskills

Determination of need:

In order to receive the Day Services Program, the authorizing clinician must determine that services are required to maintain the health and welfare of the member, the needs must be well documented in the member's care plan, and that the guidelines for limitations and exclusions have been met.

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LIMITATIONS/EXCLUSIONS:

The service must take place in a non-residential setting separate from member's private residence or other residential living arrangement.

KEY CARE PLANNING CONSIDERATIONS:

As above, the care team must carefully ensure that services authorized are non-duplicative and not overlapping.

AUTHORIZATION:

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not signify that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

Day Services requires prior authorization. S5102 UD Day services per day

REGULATORY NOTES:

Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria. This MNG references the specific regulations, coverage, limitations, service conditions, and/or prior authorization requirements in the following:

https://www.mass.gov/doc/appendix-d-dementia-day-service/download
http://www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-home-community-based-services.pdf http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-357.pdf
http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/114-3-54.pdf

RELATED REFERENCES:

Disclaimer

This Medical Necessity Guideline is not a rigid rule. As with all of CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less

costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

ATTACHMENTS:

EXHIBIT A	
EXHIBIT B	

REVISION LOG:

REVISION DATE	DESCRIPTION
12/31/23	Utilization Management Committee approval

APPROVALS:

David Mello	Senior Medical Director, Utilization Review and Medical Policy
CCA Senior Clinical Lead [Print]	**Title [Print]**
	12/31/23
Signature	**Date**
CCA Senior Operational Lead [Print]	**Title [Print]**
Signature	**Date**
Nazlim Hagmann	Chief Medical Officer
CCA CMO or Designee [Print]	**Title [Print]**
	12/31/23
Signature	**Date**