Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Adult Medical Day Care for Tufts Health RITogether

Effective: August 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☐ Tufts Health Plan Commercial products; 617-972-9409

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☐ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-972-9409
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-972-9409
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-972-9409

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Adult medical day care services in community-based facilities provide structured, individualized programs to meet the physical and/or cognitive health needs of adults with disabilities, living at home, who are unable to care for themselves for long periods of time. Adult day programs provide a variety of care management, including nursing, nutritional, therapeutic, personal care, educational and family support services in a protective, medically supervised setting during daytime hours. Members return to their home and caregiver(s) at the end of the day. Nursing, functional, and social supports are tailored to meet the unique needs of program participants and their family caregivers.

Members need to meet, at a minimum, a preventive level of care, as determined by the RI Executive Office of Health and Human Services (EOHHS) Office of Long-Term Service Supports, in order to receive adult day care services:

1. Member has a chronic illness or disability that requires, at a minimum:
    a. Supervision with **2 or more** activities of daily living (ADLs) such as, bathing, eating, dressing, toileting, and ambulation/transfers; **or**
    b. Extensive or greater assistance with **at least 3** instrumental activities of daily living (IADLs) such as meal preparation, laundry, shopping, and cleaning.
2. There must be no other person or agency available to perform these services.
3. The criteria will be based on (1) a physician or other licensed practitioner's assessment **and** (2) a DHS caseworker or EOHHS nurse's assessment.

Providers will need to check Member Eligibility on the Healthcare Portal to determine if the recipient is entitled to Adult Day Care Services. If the recipient is enrolled in one of the following waivers, then the person qualifies to receive the service: Preventive, Core Community, DEA Community, Habilitation Community, Shared Living and Intellectual Disabilities

Clinical Guideline Coverage Criteria

1. The Member must have a medical or mental dysfunction that involves one or more physiological systems and indicates a need for nursing care, supervision, therapeutic services, support services, and/or socialization.
2. The Member must require services in a structured adult day health setting.
3. The Member must have personal physician that can attest to the Member's need.
4. Adult day health service provider must complete a health assessment for admission; establish an oversight and monitoring process for the program that involves a licensed nurse; and provide standard and ad hoc reporting on this project.

There are two levels of adult day care, basic and enhanced.

- **Basic** is the provision of services by the ADC provider of an organized program of supervision, health promotion, and health prevention services that include the availability of nursing services and health oversight, nutritional dietary services, counseling, therapeutic activities, and case management
- **Enhanced** is the provision of services by the ADC provider when the participant meets at **least one** of the five requirements:
    - Daily assistance, on site in center, with at least two activities of daily living
    - Daily assistance, on site in center, with at least one skilled service, by registered professional nurse (RN) or licensed practical nurse (LPN)
    - Daily assistance, on site in center, with at least one ADL which requires a two-person assist to complete the ADL
    - Daily assistance, on site in center, with at least 3 ADL's when supervision and cueing are needed to complete the ADL's identified
    - An individual who has been diagnosed with Alzheimer's disease or other related dementia, or mental health diagnosis, as determined by a physician, **and** requires regular staff interventions due to safety concerns related to elopement risk or other behaviors and inappropriate behaviors that adversely impact themselves or others. Such behaviors and interventions must be documented in the participant's care plan and in the required progress notes.

Definitions:

Activities of daily living (ADL's) are defined as basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring.

Instrumental activities of daily living (IADL's) are defined as a range of activities that are more complex than those needed for ADLs, including meal preparation, shopping, housework, using the telephone, and taking medications.

*Daily assistance= every day of attendance

Limitations

1. Individuals who reside in a facility-based setting
2. Days or portion of day(s) not attended by Member
3. If admission of the individual to adult day health services would result in the individual receiving duplicative or substantially identical services as those provided by any other Medicaid funded service that the individual has chosen, then the individual will not be eligible for adult day health services. Ambulatory care settings include but are not limited to, the home, personal care attendant services, a physician's office, a hospital outpatient department, a partial care/partial hospitalization program, and an adult day training program.
4. An adult who has partial care/partial hospitalization program services on a particular day is not eligible for adult day health services on the same day.

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
S5102	Day care services, adult; per diem
S5105	Day care services, center-based; services not included in program fee, per diem

References:

1. State of Rhode Island Department of Health. Professional Licensing and Facility Regulations; Title 216-RICR-40-10-7, Chapter 40. March 31, 2023. Available at Licensing Adult Day Care Programs (216-RICR-40-10-7) - Rhode Island Department of State. Accessed April 27, 2026.
2. State of Rhode Island Executive Office of Health and Human Services: Centers for Medicare & Medicaid Services Waiver List;11-W-00242/1 TITLE: Rhode Island Comprehensive Demonstration. Available at Rhode Island Demonstration Approval (ri.gov). Accessed April 27, 2026.
3. State of Rhode Island Executive Office of Health and Human Services. Provider Certification Standards Adult Day Care. Published December 2015. Available at https://www.nhpri.org/wp-content/uploads/2019/04/State-of-Rhode-Island_Certification-Standards-ADC.pdf. Accessed April 27, 2026.
4. State of Rhode Island Executive Office of Health and Human Services. Available at Home And Community Based Services | Executive Office of Health and Human Services (ri.gov). Accessed April 27, 2026.
5. Executive Office of Health and Human Services. Preventive Level of Care Fact Sheet. Available at eohhs.ri.gov/Portals/0/Uploads/Documents/FactSheet_PreventiveLOC_finalamm1129.pdf. Accessed April 27, 2026.

Approval And Revision History

October 21, 2020: Reviewed by IMPAC, renewed without changes

Subsequent endorsement date(s) and changes made:

- December 4, 2020: Fax number for Unify updated
- December 21, 2021: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- April 4, 2022: Template updated
- December 1, 2022: Reviewed by MPAC, renewed without changes
- October 18, 2023: Reviewed by MPAC, renewed without changes; template updated
- November 2023: Rebranded Unify to One Care effective January 1, 2024
- October 17, 2024: Review by MPAC, renewed without changes effective December 1, 2024
- August 20, 2025: Reviewed by MPAC, renewed without changes effective October 1, 2025
- September 5, 2025: Fax number for Senior Care Options, Tufts Medicare Preferred HMO and Tufts Medicare Preferred PPO updated; language for Carelink removed
- June 17, 2026: Reviewed by MPAC, renewed without changes effective August 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.