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 MAINECARE BENEFITS MANUAL
 CHAPTER II

SECTION 26	DAY HEALTH SERVICES	ESTABLISHED 6/15/90 LAST UPDATED 8/5/05
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26.01 **DEFINITIONS**

- 26.01-1 **Day Health Services** are health services that are needed to insure the optimal functioning of the member that are provided through a day health service. These services must be provided under an individual plan of care and outside the member's residence.
- 26.01-2 **Day Health Program** is a service that provides day health services and is licensed by the Department of Health and Human Services (DHHS or Department), Bureau of Elder and Adult Services.
- 26.01-3 **Nursing Services** are services provided by a registered nurse and/or a licensed practical nurse within appropriate professional licensing regulations. They include, but are not necessarily limited to, monitoring health problems, monitoring and administering medication, and performing skilled tasks.
- 26.01-4 **Cuing** is any spoken instruction or physical guidance, which serves as a signal to do something. Cuing is typically used when caring for individuals who are cognitively impaired.
- 26.01-5 **Limited Assistance** describes an individual's self-care performance in activities of daily living, as defined by the Minimum Data Set (MDS) assessment process. It means that although the individual was highly involved in the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was provided:
- Guided maneuvering of limbs or other non-weight-bearing assistance three (3) or more times, or
 - Guided maneuvering of limbs or other non-weight-bearing assistance three (3) or more times plus weight-bearing support provided only one (1) or two (2) times.
- 26.01-6 **One-person Physical Assist** requires one (1) person to provide either weight-bearing or non-weight-bearing assistance for an individual who could not perform the activity independently in the preceding seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting. This does not include cuing.
- 26.01.7 **Extensive Assistance** means although the member performed part of the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours in a hospital setting, help of the following type(s) was provided:
- Weight-bearing support three (3) or more times, or
 - Full staff performance during part (but not all) of the last seven (7) days.

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26.01 **DEFINITIONS** (cont.)

26.01-8 **Medical Eligibility Determination (MED) Form** is the form approved by the Department for medical eligibility determinations and service authorization for the plan of care based upon the assessment outcome scores. The definitions, scoring mechanisms and time frames relating to this form are outlined in the MED form and provide the basis for services and the care plan. The care plan summary contained in the MED form documents the authorized service plan. The care plan summary also identifies other services the member is receiving, in addition to the authorized services provided under this Section.

26.01-9 **Authorized Agent** is the contractor selected by the Department of Health and Human Services to conduct face-to-face assessments and reassessments of member eligibility, using the DHHS Medical Eligibility Determination form, and the timeframes and definitions within it, to determine medical eligibility for covered services.

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26.01-10 **Significant Change** means a major change in the member's status that is not self limiting, affects more than one (1) area of functional health status, and requires a multi-disciplinary review or revision of the authorized plan of care. A self-limiting condition is one that will normally resolve itself within two (2) weeks without further intervention or by staff implementing standard disease related clinical intervention.

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26.01-11 **Significant Change Assessment** means the process by which the Department or its authorized agent determines whether a member has sustained a Significant Change. A Significant Change Reassessment is appropriate if the member exhibits two (2) or more instances of either improvement or decline that affect the member's physical condition.

26.02 **ELIGIBILITY FOR CARE**

26.02-1 **General Requirements**

A member is eligible to receive services as set forth in this Section if he or she meets the general MaineCare eligibility requirements and the specific MaineCare eligibility requirements. Members must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

26.02-2 **Specific Day Health Services Eligibility Requirements**

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The member must be assessed by the Department or the Department's authorized agent, using the Department's approved medical eligibility assessment form. A member must require assistance with a combination of activities of daily living and nursing at specific levels in order to meet eligibility for specific levels of care. A member is medically eligible for day health services under this section if he or she meets the criteria set forth in (A), (B) or (C) below:

26.02 **ELIGIBILITY FOR CARE** (cont.)

A. Level I: A member meets the eligibility requirements for Level I if the following are met:

1. Member requires daily (seven (7) days per week) “Cuing” (defined in Section 26.01) for all items: 26.02-2 (A) (2), (d), (e), (f) and (g) listed below;

or

2. At least “limited assistance” (defined in 26.01) and a “one-person physical assist” (defined in 26.01) are needed with at least two (2) of the following activities of daily living:
 - a. Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;
 - b. Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);
 - c. Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;
 - d. Eating: How person eats and drinks (regardless of skill);
 - e. Toilet Use: How person uses the toilet room (or commode, bedpan, urinal): transfers on/off toilet, cleanses, changes pad, managed ostomy or catheter, adjusts clothes;
 - f. Bathing: How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and
 - g. Dressing: How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

B. Level II: A member meets the eligibility requirements for Level II if the following are met:

1. At least “extensive assistance” (defined in 26.01) and a “one-person physical assist” (defined in 26.01) are needed for at least two (2) of the following five (5) activities of daily living listed in 26.02-2 (A) (2) above: bed mobility, transfer, locomotion, eating, toilet use.

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26.02 **ELIGIBILITY FOR CARE** (cont.)

2. Member meets two (2) of the following three (3) criteria:
 - a. Cognition Threshold:
 - i. Scores a one (1) on Section C.1a of the MED form on short-term memory (recall after five (5) minutes). A score of one (1) indicates memory problems; and
 - ii. Can recall no more than two (2) of the following items from Section C.2 of MED form, Memory/Recall Ability: current season, location of own room, names/faces, where he/she is; and
 - iii. Scores a two (2) or three (3) under Section C.3 of MED form, Cognitive Skills for Daily Decision-Making. Moderately impaired (decisions poor; cues/supervision required) will be scored as two (2) and severely impaired (never/rarely made decisions) will be scored as three (3).
 - b. Behavior threshold: member must score a two (2) or three (3) under Section D.1 of the MED form, Problem Behavior. This behavior includes wandering, being verbally abusive, physically abusive, and/or demonstrating socially inappropriate behavior four (4) or more days per week.
 - c. At least “limited assistance” (defined in 26.01) and a “one-person physical assist” (defined in 26.01) is needed for at least one (1) of the following five (5) activities of daily living listed in 26.02-2 (A) (2) above: bed mobility, transfer, locomotion, eating, toilet use.
- C. Level III: A member must meet the medical eligibility requirements detailed in Chapter II, Section 67.02, Nursing Facility Services.

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26.03 **DURATION OF CARE**

A member is eligible for as many MaineCare covered services as are specified in his or her individual plan of care. Beginning and end dates of a member’s medical eligibility determination period correspond to the beginning and end dates for MaineCare coverage of the plan of care established by the Department or the Department’s authorized agent.

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26.04 **COVERED SERVICES**

Day Health. Day health services are those services provided outside the member's residence at a site licensed by the Bureau of Elder and Adult Services, on a regularly scheduled basis. The ongoing service may include, based on individual needs:

26.04 COVERED SERVICES (cont.)

- monitoring of health care
- supervision, assistance with activities of daily living
- nursing
- rehabilitation
- health promotion activities
- exercise groups
- counseling

Noon meals and snacks are provided as a part of day health services.

26.05 LIMITATIONS

- A. Members eligible for Level I of care may receive up to sixteen (16) hours per week of covered services under this Section.
- B. Members eligible for Level II of care may receive up to twenty-four (24) hours per week of covered services under this Section.
- C. Members eligible for Level III of care may receive up to forty (40) hours per week of covered services under this Section.

26.06 NON-COVERED SERVICES

Refer to Chapter I, General Administrative Policies and Procedures for rules governing non-covered services in general. Day health services delivered to a member who is a resident in a private non-medical institution (PNMI) cannot be reimbursed under this rule.

26.07 POLICIES AND PROCEDURES

26.07-1 Professional Staff

Day health services are to be provided by the following staff in accordance with the individual written plan of care. Staff may be day health service employees or consultants to the service.

The following professional staff who are fully, provisionally or conditionally licensed or recognized to practice by the state or province in which services are provided, are qualified professional staff.

- A. Registered Nurse
- B. Practical Nurse
- C. Social Worker
- D. Occupational Therapist
- E. Physical Therapist
- F. Speech Language Pathologist

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26.07 **POLICIES AND PROCEDURES** (cont.)

- G. Other Qualified Staff may include CNAs and other service aides and assistants who provide day health services appropriate to their level of training under the supervision of a licensed professional who falls within the categories listed in subsections A through F, above. Supervision may be provided on a consulting basis.

26.07-2 **Eligibility Determination**

Applicants under this section must meet the eligibility requirements set forth in Section 26.02. An eligibility assessment, using the Department's approved MED assessment form, shall be conducted by the Department or the Department's authorized agent.

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- A. If financial eligibility for MaineCare has not been determined, the applicant, family member or guardian must be referred to the regional office of the Bureau of Family Independence, concurrent with the relevant medical eligibility determination process.

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- B. The Department or the Department's authorized agent shall conduct a medical eligibility assessment using the Department's approved MED assessment form to determine the number of hours for MaineCare covered services under this Section.

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- C. The provider must implement a plan of care that does not exceed the total hours authorized by the Department or the Department's authorized agent each week.

- D. The anticipated costs of services under this Section under the plan of care must conform to the service limitations set forth in Section 26.05.

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- E. The Department or the Department's authorized agent must approve a classification period for the member, based on the scores, timeframes and needs identified in the MED assessment for the covered services, and the assessor's clinical judgment. A classification period must not exceed twelve (12) months. The authorized agent will notify the Department of each member classified, the member's medical eligibility start dates and the reassessment date. Thereafter, the authorized agent will forward the completed MED forms, eligibility notices, and other assessment paperwork to the provider chosen by the member.

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- F. If the Department or its authorized agent determines that the member does not meet or no longer meets the medical eligibility criteria, or is eligible for a different level of care, then the Department or its authorized agent must notify (using a notice format approved by the Department) the member in writing of which services, if any, will be provided, or which services will be provided on

26.07 **POLICIES AND PROCEDURES** (cont.)

a reduced basis. The notice must contain an understandable explanation of the reasons, inform the member of his or her appeal rights, and conform to the notice requirements in Chapter I.

26.07-3 Plan of Care

A written plan of care must be established before services are provided. To be reimbursed, services must be consistent with the plan of care. At least one (1) of the persons involved in developing the initial care plan must be a registered nurse or an LPN under the supervision of a registered nurse.

The written plan of care shall include, but is not necessarily limited to:

- A. member's name, address, birth date
- B. name of member's physician, if any
- C. type of day health services needed
- D. who shall deliver the service
- E. frequency and expected duration of the services
- F. long and short term goals
- G. plans for coordinating with other health and social service agencies for the delivery of services (see Medical Eligibility Determination (MED) form).

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At least one (1) professional staff person, such as a nurse or social worker, shall be responsible for the development and monitoring of care plans. The care plan is to be reviewed and updated at least every six (6) months or more often as necessary by nurse or social worker.

The plan of care should be included as a subsection of a master plan of care if multidisciplinary services are provided to a member and are coordinated by a care manager.

26.07-4 Reclassification for Continued Services

Reassessment and prior authorization of services is required for all members in order for the reimbursement of services to continue uninterrupted beyond the approved classification period. The provider must request the reassessment no more than fourteen (14) days prior to the reclassification date. The Department or its authorized agent must conduct the reassessment no later than the reclassification date. MaineCare coverage ends on the classification period end date unless a new classification period

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26.07 **POLICIES AND PROCEDURES** (cont.)

has been authorized. The provider may request an unscheduled reassessment if a significant change occurs as defined in Section 26.01.

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26.07-5 **Member Records**

There must be a specific record for each member, which must include, but not necessarily be limited to:

- A. member's name, address, sex, age, next-of-kin;
- B. the Department's approved medical eligibility assessment form;
- C. medical information, including:
 - 1. statement of significant medical problems
 - 2. written physician orders of current medications and treatments to be delivered at the day health setting
 - 3. statement of limitations, if any, on the member's participation in service activities
 - 4. recommendations for therapies;
- D. list of medications, prescribed and otherwise;
- E. written plan of care;
- F. summary notes for each date of service billed which include:
 - 1. identification of the service provided, the date and provider;
 - 2. signature of service provider;
 - 3. date and full description of any unusual condition or unexpected event; and
- G. monthly progress notes reflecting the progress that the member has made in relation to the plan of care. The licensed professional responsible for monitoring the plan of care must sign the progress notes, in conformance with licensing requirements.

26.07 **POLICIES AND PROCEDURES** (cont.)

26.07-6 **Member Appeals**

A member has the right to appeal in writing or orally any decision made by the Department or its authorized agent, to reduce, deny or terminate services provided under this benefit. In order for services to continue during the appeal process, a request must be received by the Department within ten (10) days of the notice to reduce or terminate services. Otherwise, an individual has sixty (60) days in which to appeal a decision. Members shall be informed of their right to request an Administrative Hearing in accordance with this Section and Chapter I of this manual.

An appeal for members must be requested in writing or orally to:

Director
Bureau of Elder and Adult Services
c/o Hearings
11 State House Station
Augusta, ME 04333-0011

26.07-7 **Program Integrity**

All providers are subject to the Department's Program Integrity (formerly Surveillance and Utilization Review) activities. Refer to Chapter I, General Administrative Policies and Procedures for rules governing these functions.

26.08 **REIMBURSEMENT**

Reimbursement for covered services shall be the lower of:

- A. The provider's usual and customary charge; or
- B. The amount listed in the "Allowances for Day Health Service", Chapter III.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment prior to billing MaineCare.

Reimbursement for services provided by licensed professionals listed in Section 26.07-1 on a consulting basis is included in the day health service reimbursement rate. The consulting provider must not bill separately for these services except for physical therapy, occupational therapy services, and speech therapy that are provided on an individual basis, rather than in a group, according to physician orders and a plan of care. These services may be billed in

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26.08 **REIMBURSEMENT** (cont.)

accordance with Chapter II, Section 68, Occupational Therapy Services; Chapter II, Section 85, Physical Therapy Services; or Chapter II, Section 109, Speech-Language Pathology Services, of the MaineCare Benefits Manual.

Day health services provided to members of the Department's Home and Community Benefits for the Elderly and for Adults with Disabilities must be reimbursed under the relevant rule, and not under this Section.

26.09 **BILLING INSTRUCTIONS**

Providers must bill in accordance with the Department's Billing Instructions.