Clinical Policy: Medical Day Care (Adult and Pediatric Day Health Services)

Reference Number: NJ.CP.MP.503
Date of Last Revision: 01/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This policy describes the medical necessity requirements for medical day care services in New Jersey.

Policy/Criteria
I. It is the policy of Fidelis Care of New Jersey that Adult Medical Day Care services are **medically necessary** for the following indications:
- A. Limited assistance needed in at least two of the following activities of daily living (ADLs):
  1. Bathing (documented along with rationale) / dressing (must be assistance with upper and/or lower dressing to be considered one ADL);
  2. Toilet transfer and/or toilet use (counts as one ADL);
  3. Transfer, locomotion, or walking (Locomotion includes how member moves between locations on the same floor [walking or wheeling]; If in a wheelchair, self-sufficiency must be demonstrated once in chair; Walking [includes how the member walks between locations on the same floor, indoors]);
  4. Eating;
  5. At least one needed skilled service provided daily by a registered professional nurse or licensed practical nurse, or rehabilitation services (e.g., physical therapy, occupational therapy, speech-language pathology) provided for a time-limited period in order to attain particular treatment goals identified by the attending physician, physician assistant, or advanced practice nurse. The needed skilled services include, but are not limited to:
     a. Oxygen need;
     b. Ostomy care;
     c. Daily nurse monitoring (for example, medication administration pacemaker checks, urinary output, unstable blood glucose, unstable blood pressure with physician/advanced practice nurse intervention);
     d. Skin treatment of wounds;
     e. Treatment of stasis ulcers;
     f. Intravenous or intramuscular injections;
     g. Nasogastric or gastrostomy tube feedings and medical nutrition therapy.
  6. Needed skilled services shall be provided on-site in the facility. The rehabilitation services include:
     a. Physical therapy;
     b. Occupational therapy;
     c. Speech-language pathology services;

d. Rehabilitation services may be provided off-site.*

*Note: Notwithstanding the provisions of any law or regulation to the contrary, the amounts hereinabove appropriated within the general Medical Services program classification for Medical Day Care Services shall be conditioned on the following provision: Physical therapy, occupational therapy, and speech therapy *shall no longer serve as a permissible criteria for eligibility* in the adult Medical Day Care Program.

B. Member requires supervision / cueing *in at least three of* the following ADLs: *bathing* (documented along with rationale), *dressing* (must be assistance with upper and/or lower dressing to be considered one ADL)*, toilet use, transfer, locomotion,* and *eating.* In addition, the following criteria must be met:
   1. Facility will provide all of the supervision/cueing for the claimed ADLs on-site in the facility;
   2. Member exhibits problems with short-term memory;
   3. Difficulties with following multitask sequences, and has some difficulty in daily decision-making in new situations or greater level of impairment, as measured by the assessment instrument prescribed by the Department;
   4. Bathing, including how the member: takes a full-body bath or shower; transfers in and out of the tub or shower; and bathes each part of the body (including arms, upper and lower legs, chest, abdomen, and perineal area – excludes washing of back and hair);
   5. In order to apply this ADL, need for ADHS eligibility, the member must receive bathing assistance ON-SITE in the facility;
   6. Documentation must be in the assessment narrative to support the use of Bathing as an ADL in ADHS setting;
      Note: Cleansing after incontinence episodes is captured in the *ADL Toilet Use* and is not considered bathing;
   7. Dressing the Upper Body. Includes how the member dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.;
   8. Dressing the Lower Body. Includes how the member dresses and undresses (street clothes, underwear) from the waist down, including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.;
   9. In order to apply ADL's to ADHS eligibility, the member must receive dressing assistance ON-SITE in the facility;
   10. Documentation must be in the assessment narrative to support the use of dressing as an ADL in ADHS setting;
       Note: Adjusting or changing clothing with toileting is captured in the *ADL Toilet Use* and is not considered Dressing. Assistance with outerwear (jackets, gloves, hats, etc.) is not considered dressing;
   11. To qualify under Cognition in this manner, the three eligible ADLs must be coded as:
       a. Supervision/Cueing (or greater - 3, 4, 5, 6);
       b. Cognitive components must be coded as:

i. Cognitive Skills for Daily Decision Making:
   a) Modified Independence;
   b) Minimally impaired;
   c) Moderately impaired;
   d) Severely impaired.

12. Short Term Memory and Procedural Memory:
    a. Memory Problem.

    Note: Rehabilitation service means physical therapy, occupational therapy, and/or speech-language pathology.

13. Skilled service means a needed skilled service provided by an RN or LPN, including, but not limited to:
    a. Oxygen needs;
    b. Ostomy care;
    c. Nurse monitoring (for example, medication administration, pacemaker checks, or the monitoring of urinary output, unstable blood glucose or unstable blood pressure that *requires physician and/or advanced practice nurse intervention*);
    d. Wound treatment;
    e. Stasis ulcer treatment;
    f. Intravenous or intramuscular injection;
    g. Nasogastric or gastrostomy tube feeding;
    h. Medical nutrition therapy.

C. Satisfy the following clinical eligibility and prior authorization requirements per N.J.A.C. 8:86-1.5: Clinical eligibility for adult day health services shall be contingent upon receipt of prior authorization from the State on the basis of:

1. The results of an assessment of the member using an instrument prescribed by the State and the eligibility criteria specified below. The prescribed assessment instrument is designed to collect standardized information on a broad range of domains critical to caring for members in the community, including items related to cognition; communication/hearing; vision; mood and behavior; social functioning; informal support services; physical functioning; continence; disease diagnoses; health conditions; preventive health measures; nutrition/hydration; dental status; skin condition; environment/home safety; service utilization; medications; and socio-demographic/background information;
2. The State's evaluation and consideration of information received from either the facility (or Medical Day Care) RN (where services are based), the member and/or the member's legally authorized representative, personal physician or other healthcare professional who has current and relevant knowledge of the member, the member's medical or psychosocial needs and the member's ADL or cognitive deficits. Such information may be considered by the State along with the results of the assessment performed above and the eligibility criteria below as the basis for determining clinical eligibility for adult day health services.

3. Clinical eligibility assessments shall be performed by professional staff designated by WellCare prior to the initial provision of ADHS to a member, at least annually after the initial authorization of services and, in accordance below, when a member presents a change in status that may alter the member's eligibility to receive ADHS. ADHS facilities shall retain, as part of each member's permanent record, a signed acknowledgement of the member or the member's legally authorized representative, as appropriate, that a determination of eligibility to receive ADHS is not permanent and redeterminations will be made on the basis of annual assessments. When an adult member presents a change in status that facility staff document in the plan of care pursuant to N.J.A.C. 8:43F-5.4 and that may alter the member's eligibility to receive ADHS, the facility shall complete one of the following:
   a. Discharge the member pursuant to N.J.A.C. 8:43F;
   b. Contact the State to request a clinical eligibility assessment for that member by submitting a pre-numbered prior authorization request form in accordance with N.J.A.C. 8:86-1.3(a)3 and providing the reason for the request.

4. In addition, a home visit assessment shall be completed and include the following:
   a. Living arrangements;
   b. The member's relationship with his or her family;
   c. The member's home environment;
   d. The existence of environmental barriers, such as stairs, not negotiable by the member;
   e. Access to transportation, shopping, religious, social, or other resources to meet the needs of the member;
   f. Other home care services received, including documentation of the frequency and amount of each service received;

For full language of the New Jersey Legislature, including authorizations, facility requirements, assessments performed by the ADHS facility, please refer to Chapter 164 (http://www.lexisnexis.com/hottopics/njcode/).

Voluntary Transfer Between ADHS Facilities

D. An adult member who chooses to request to transfer from one ADHS facility to another ADHS facility shall submit a transfer request, in accordance with one of the below, to:
   1. The facility to which the member chooses to request to transfer;
   2. The member's care manager if the member is a participant of any program listed at N.J.A.C. 10:164-1.1(b) that requires care management.

E. A request for transfer to another ADHS facility shall be in writing and include the following:
   1. The member's name, address, and date of birth;
   2. The name of the ADHS facility at which the member is receiving ADHS;
   3. The valid reason(s), as identified below, upon which the requestor bases the transfer request;

4. The name of all ADHS facilities the member has attended, including dates attended;
5. The signature of the member and/or the member's legally authorized representative.

F. Any one of the following is a valid reason for a transfer to another ADHS facility:
   1. The member is changing his or her residence;
      a. A request to transfer based on this reason shall contain the address of the member's new residence;
   2. The transportation time between the member's home and the ADHS facility to which the member chooses to request to transfer is shorter than the transportation time between the member's home and the ADHS facility in which the member is enrolled as a participant, and the member prefers to have a shorter transportation time;
   3. The member believes that the facility from which the member chooses to request to transfer violated his or her rights as a participant of that facility pursuant to N.J.A.C. 8:43F-4.2;
      a. A request to transfer based on this reason shall describe the nature of the violation;
   4. The transfer is medically necessary as identified by the member's attending physician, physician assistant, or advanced practice nurse;
      a. A request to transfer based on this reason shall include the written statement of the member's attending physician, physician assistant, or advanced practice nurse indicating the basis of the medical necessity.

A care manager in receipt of a member's request to transfer to another ADHS facility shall forward the request to the ADHS facility to which the member wishes to transfer with written notification providing the number of days per week the member may receive ADHS pursuant to N.J.A.C. 10:164-1.3(a)3 and 1.4(a)3.

Upon receipt of a member's written transfer request and, if applicable, the written notice from the member's care manager providing the number of days per week the member may attend the facility if the request was made pursuant to Section D. above, the ADHS facility to which the member chooses to request to transfer shall submit a pre-numbered prior authorization request form with the original written transfer request to the State in accordance with N.J.A.C. 10:164-1.3(a)3, with the exception that the facility shall mail the submission to the following:

Adult Day Health Services Program
Office of Community Choice Options
Division of Aging Services
New Jersey Department of Human Services
PO Box 807
Trenton, NJ 08625-0807

Prior to the submission of the pre-numbered prior authorization request form, the transferee facility shall notify the ADHS facility from which the member chooses to request to transfer of the member's pending transfer request.

Within 30 days of the date the Department receives the written transfer request, the Department shall take one of the actions specified below and shall notify the member, the ADHS facility to which the member chooses to request to transfer, and if applicable, the member's case or care manager, of the Department's decision:

- Approve a transfer request that presents at least one of the valid reasons provided in Section F. above;
- Approve a transfer request that does not present one of the valid reasons provided in Section F. above, if the Department has not approved a request to transfer without a valid reason for the member within one year of receipt of the current request;
- Deny a transfer request that does not present one of the valid reasons provided above that is submitted within one year of an approval of a previous submission of a request to transfer without a valid reason in accordance with Section F. above; or
- Request additional information if the written transfer request does not provide the requested information identified above in Section F.[7]

Adult Day Services for Person's With Alzheimer's Disease or Related Disorders

II. It is the policy of Fidelis Care of New Jersey that Adult Medical Day Services (AMDS) for members with Alzheimer's disease or related disorders, are considered **medically necessary** when the following criteria are met:

A. Have a diagnosis by a physician of Alzheimer's disease, or a related disorder such as multi-infarct dementia, Huntington's disease, Parkinson's disease with dementia, Creutzfeldt Jacob disease, or Pick's disease;
B. Be a resident of New Jersey;
C. Be routinely cared for by a family member or informal caregiver who does not receive financial remuneration for the care;
D. Reside in the community with a relative or informal caregiver;
E. Have liquid resources (as declared by that member) that do not exceed $ 40,000. A couple's combined liquid resources shall not exceed $ 60,000;
F. Have income that falls within the income limits established in N.J.A.C. 10:164A-3.2(c).[3] Note: Priority shall be given to those members in moderate to severe ranges of disability.
G. The scope of services or required services for members with Alzheimer's Disease or a Related Disorder shall include (§ 10:164A-1.3):
    1. A structured program supervised by the Medical Day Care staff shall be provided for clients based on a care plan developed through an assessment of member strengths and deficits related to physical, social, emotional, and cognitive functioning. The care plan shall be reviewed by the Medical Day Care staff on a quarterly basis, modified as necessary, and shall include identified short term and long term goals of implementation. Discharge planning, initiated at the time of admission, shall address the potential for progressive deterioration which would alter the appropriateness of

day care and necessitate helping the caregiver to access alternative resources. The discharge plan may be incorporated into the care plan;

2. A minimum of five hours of structured programming per day shall be provided to clients funded through this program. In addition, the facility shall provide an area for member attention and supervision, as appropriate;
3. Clients shall receive a hot meal and nutritious snacks. Each meal shall contain at least one-third of the Food Nutrition Board Recommended Dietary Allowances, 10th edition, Washington, DC: National Academy Press, 1989, incorporated herein by reference, as amended, and supplemented, and shall contain three or more menu items, one of which is or includes a high quality protein food such as meat, fish, eggs, or cheese. Provisions shall be made for clients on special diets;
4. Transportation shall be provided or arranged for clients within the facility's catchment area except when a family member has chosen to fulfill that responsibility. No client shall be transported more than one hour each way by the facility. Facilities shall not charge transportation costs to families if transportation is factored into their cost proposal;
5. Counseling and referral services shall be routinely available to family members and caregivers of clients served under this program. Counseling may be on a one-to-one basis or in the form of support groups sponsored by the facility. In the event that the facility does not sponsor a support group, it may refer caregivers to other support groups for caregivers of members with dementia within the catchment area. Referral activities shall include identifying and assisting caregivers and assessing other services which will aid them in sustaining their roles;
6. Educational programs for family members related to the management of dementia shall be provided by the facility. The center may provide educational programs using existing staff or may enter into written agreement(s) with other local facilities for the provision of this service.

Pediatric Medical Day Care (PMDC)

III. It is the policy of Fidelis Care of New Jersey that Pediatric Medical Day Care (PMDC) services are **medically necessary** when the following criteria are met:

A. The initial functional assessment shall consist of the following:
   1. An interview with the Medicaid member's parent(s);
   2. Observation of the Medicaid member;
   3. A review of the Medicaid member's medical status in the past six months with attention to changes in symptoms, feeding, medications or activity and to intervening events, such as hospitalization or acute illness;
   4. A detailed review of the skilled nursing needs of the Medicaid member during a typical 24-hour period, including, but not limited to:
      a. Dependence on mechanical ventilation;
      b. The presence of a tracheostomy requiring frequent suctioning;
      c. The presence of pulmonary insufficiency requiring positioning, suctioning and/or chest physical therapy;

d. Need for enteric feeding complicated by either gastroesophageal reflux and risk of aspiration or by a need for frequent venting of the tube, or both;
e. The presence of diabetes requiring frequent blood sugar testing and medication adjustment;
f. The presence of a seizure disorder manifested by frequent and prolonged seizures requiring emergency medication administration;
g. The presence of moderate persistent or severe persistent asthma requiring nebulizer treatments more than twice a day and frequent medication adjustment in accordance with the Asthma Guidelines;
h. The need for intermittent bladder catheterization;

B. A detailed review of all other elements of the Medicaid member's care needs during a typical 24-hour period, including a review of:
   1. Who provides care to the member;
   2. The type of care the member receives;
   3. The locations at which the member receives each type of care;
      If the member receives private-duty nursing, the quantity of time (that is, the number of hours) during which, and the times and locations at which, the member receives private-duty nursing;
C. An evaluation and consideration of information about the Medicaid member's medical, rehabilitative, developmental, and psychosocial needs received from the nursing director, the child's primary health care provider and/or other healthcare professionals who have current and relevant knowledge of the Medicaid member;
D. The family composition, ages of any siblings residing with the Medicaid member and the available community support.
E. Professional staff designated by the State performing the functional assessment shall document, in writing, the results of the functional assessment, which writing shall contain, at a minimum, the following:
   1. Medicaid member identification information, including name, date of birth, gender, address, telephone number and Medicaid identification number;
   2. A narrative of the Medicaid member's current medical status, past medical history, and any additional considerations;
   3. A determination that the Medicaid member is or is not a technology-dependent child and/or a medically complex child and a written summary of findings supporting that determination;
   4. The name and title of the professional staff designated by the State who performed the functional assessment and the date the functional assessment was completed.
F. Professional staff designated by the State shall perform the functional assessment (New Jersey Choice Tool):
   1. Prior to initial provision of services to a Medicaid member;
   2. When the interdisciplinary plan of care reflects a change in status that may alter a PMDC member's eligibility to receive PMDC;
   3. At least every 180 days after the initial and each subsequent assessment.

Background

Adult Medical Day Health (AMDH) and Pediatric Medical Day Health (PMDH) services are concerned with the fulfillment of the health needs of eligible members who could benefit from a health services alternative to total institutionalization. AMDH and PMDH services provide medically necessary services in an ambulatory care setting who, due to their physical and/or cognitive impairment, require such services supportive to their community living. To be eligible for medical day care a member needs to meet specific criteria related to activity of daily living and/or cognitive/memory deficit or be in need of daily skilled services that require health professional supervision and/or monitoring. ADHS must be provided a minimum of five hours per day, not to exceed five days per week. Adult Day Health services offer medical, nursing, social, personal care, and rehabilitative services, as well as a nutritious midday meal, and activities).[3]

Pediatric Medical Day Care (PMDC) services provides medically necessary services in an ambulatory care setting to children who reside in the community and who, because they are technology-dependent and/or medically complex, require continuous rather than part-time or intermittent care of a registered professional nurse in a developmentally appropriate environment and whose needs cannot be met in a regular day care or pre-school handicapped program. Pediatric day health services are available only for medically unstable children who require continuous, rather than part-time or intermittent, care of a licensed practical or registered professional nurse in a developmentally appropriate environment.[2]

Technology Dependent Child means a child who requires a specific class III medical device (e.g., implantable pacemaker, continuous ventilator, pulse generator) to compensate for the loss of a vital body function to avert death or further disability and ongoing skilled nursing intervention in the use of the device. A class III medical device is defined as devices requiring a premarket approval application (PMA) unless the device is a preamendments device (on the market prior to the passage of the medical device amendments in 1976, or substantially equivalent to such a device) and PMA's have not been requested. In that case, a 510k will be the route to market.[1] Products requiring PMAs are Class III, high risk devices that pose a significant risk of illness or injury, or devices found not substantially equivalent to Class I and II predicate through the 510(k) process.[5]

Medically Complex Child describes a child who exhibits a severity of illness that requires ongoing skilled nursing intervention.[2]

A PMDC member attending a PMDC facility shall receive one unit of service per day (one unit of services equals one day), excluding transportation time, not to exceed five units of service per week**,** in accordance with a primary health care provider's written order and authorization by professional staff designated by the State pursuant to N.J.A.C. 8:87-3.4.[2]

Ambulatory care settings for AMDH services are provided in a facility or a distinct part of a facility which is licensed by the New Jersey Department of Health to provide preventive, diagnostic, therapeutic, and rehabilitative services under medical and nursing supervision to meet

the needs of functionally impaired adult participants who are not related to the members of the governing authority by marriage, blood, or adoption.[4] Adult day health services facilities provide services to participants for a period of time, which does not exceed 12 hours during any calendar day. PMDH services are provided in a facility which provides additional services in order to provide for the needs of technologically dependent or medically unstable children.[3]

In addition, a PMDC facility shall be equipped and staffed to accommodate no fewer than six medically complex children and/or technology-dependent children in accordance with N.J.A.C. 8:43J. All prescribed therapies shall be included in the interdisciplinary plan of care and shall be provided according to the written, dated, and signed orders of the PMDC member's primary health care provider. Pediatric Medical Day Care (PMDC) admission and Medicaid reimbursement for PMDC shall be contingent upon a Medicaid member's receipt of authorization from the State pursuant to N.J.A.C. 8:87-3.4 and the performance of an initial functional assessment of the Medicaid member by professional staff designated by the State that results in a determination that the Medicaid member is a medically complex and/or technology-dependent child who requires PMDC facility services pursuant to N.J.A.C. 8:87-5.[2]

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
97799	Unlisted physical medicine/rehabilitation service or procedure

HCPCS Code	Description
S5100	Day care services, adult; per 15 minutes
S5101	Day care services, adult; per half day
S5102	Day care services; adult; per diem
S5105	Day care services, center-based; services not included in program fee, per diem
W9002	Adult day health services visit
Z1860	Adult day health services visit for the AIDS Community Care Alternatives Program (ACCAP)
Z0270	Initial visit, physical therapy
Z0300	Initial visit, speech-language pathology services

HCPCS Code	Description
Z0310	Initial comprehensive speech-language pathology evaluation
Z1863	Pediatric medical day care facility visit for a technology-dependent child
Z1864	Pediatric medical day care facility visit for a medically complex child

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	6/5/2014	6/5/2014
Approved by MPC. Clarification of language.	6/30/2014	6/30/2014
Approved by MPC. No changes.	5/7/2015	5/7/2015
Approved by MPC. No changes.	6/2/2016	6/2/2016
Approved by MPC. Included revisions from the market.	12/8/2016	12/8/2016
Approved by MPC. Included revisions from the market.	10/5/2017	10/5/2017
Approved by MPC. No changes.	10/4/2018	10/4/2018
Approved by MPC. Updated coverage requirements.	10/3/2019	10/3/2019
Annual review, no changes.	9/2020	
Transitioned policy to new state specific template and sent to market for ownership, Policy number changed from HS-XXX to NJ.CP.MP.503.	9/2020	
Policy template and references updated-sent to market for ownership	08/23	
Policy retired.		11/23
Policy reinstated.	1/24	
Annual review. Duplicative language removed from Criteria II. for clarity with no impact to criteria. Minor rewording with no impact to criteria. Codes reviewed. References reviewed and updated. Sent to market for ownership.	01/25	02/25

References

1. United States Food and Drug Administration. Medical devices: overview of device regulation. http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/overview/. Updated January 31, 2024. Accessed October 29, 2024.
2. New Jersey State Legislature. Title 10, chapter 166: pediatric medical day care services. http://www.lexisnexis.com/hottopics/njcode/. Effective November 16, 2009 (revised January 24, 2024). Accessed October 29, 2024.
3. New Jersey State Legislature. Title 10, chapter 164 adult day health services. http://www.lexisnexis.com/hottopics/njcode/. Published June 16, 2014 (effective September 22, 2021). Accessed October 29, 2024.
4. New Jersey Department of Health. Division of Health Facilities Evaluation and Licensing Service information. https://www.nj.gov/health/healthfacilities/about-us/facility-types/index.shtml. Last reviewed January 3, 2019. Accessed October 29, 2024.

5. United States Food and Drug Administration. Medical devices: classify your medical device. Retrieved from http://www.fda.gov/medicaldevices/deviceregulationandguidance/overview/classifyyourdevice/default.htm. Updated February 7, 2020. Accessed October 29, 2024.
6. State of New Jersey Department of Human Services. Administrative Codes and Regulations. New Jersey Administrative Code (NJAC). Section 10:164-2.2; Billing codes. https://casetext.com/regulation/new-jersey-administrative-code/title-10-human-services/chapter-164-adult-day-health-services/subchapter-2-billing-codes/section-10164-22-billing-codes. Published January 2, 2001 (revised November 16, 2009). Accessed October 29, 2024.
7. New Jersey State Legislature. Title 10, chapter 164-1.7 voluntary transfer between ADHS facilities. http://www.lexisnexis.com/hottopics/njcode/. Effective January 7, 2008. Accessed November 4, 2024.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.