APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc., take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. All links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change prior to the annual review date. Lines of business (LOB) are subject to change without notice; current LOBs can be found at www.wellcare.com. All guidelines can be found at this site as well but selecting the Provider tab, then “Tools” and “Clinical Guidelines”.

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. Pediatric day health services are available only for and/or 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.

* 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. 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.

** 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 called for. In that case, a 510k will be the route to market (1FDA, 2014). Products requiring PMAs are Class III devices are 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.¹

AMDH is a program of medically supervised health related services provided in an ambulatory setting to persons who, due to their physical and/or mental impairment(s), need health maintenance and restorative services to support 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).

POSITION STATEMENT

Applicable To:
- Medicaid (Plan A) – New Jersey
- Medicaid (MLTSS) – New Jersey

NOTE: This is not a stand-alone MLTSS benefit. Any amount of service provided above the state plan limitation specified at N.J.A.C. 8:86 (five hours per day/five days per week) must be considered as MLTSS.

Adult Medical Day Care (PMDC)

Exclusions

A Member may be ineligible for ADHS if any of the three criteria below are met:

- Admission of the member to an ADHS facility would result in the member receiving a service(s) that is duplicative or redundant of any other Medicaid-funded service(s) that the member has chosen*; OR,
- Member resides at a residential health care facility; OR,
- Member requires and is receiving care 24 hours per day on an inpatient basis in a hospital or nursing home.

* Examples of services, programs and ambulatory care settings that may constitute duplicative or redundant services include, but are not limited to, services provided in an member's home, by a personal care attendant, in the office of a physician, in a hospital outpatient department, at a partial care/partial hospitalization program, and/or in an adult day training program;

In order to be eligible for services in an HIV adult day health services facility, a Member shall be at least 18 years of age with HIV infection, eligible for adult day health services in accordance with N.J.A.C. 8:86-1.1(b), and require outpatient drug abuse treatment.
**Coverage**

Adult Medical Day Services are considered medically necessary when all of the criteria are met.²

1. Member requires:

   - At least **limited assistance** in at least **two** of the following ADLs (bathing [documented along with rationale]/dressing [must be assistance with upper and lower dressing to be considered one ADL], toilet use, transfer, locomotion, and eating). The facility will provide all of the assistance for the claimed ADLs on-site where the Member is receiving services);
     
     OR,

   - 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,
   - oxygen need,
   - ostomy care,
   - daily nurse monitoring (for example, medication administration, pacemaker checks, urinary output, unstable blood glucose, unstable blood pressure with physician/advanced practice nurse intervention),
   - skin treatment of wounds
   - treatment of stasis ulcers,
   - intravenous or intramuscular injections,
   - nasogastric or gastrostomy tube feedings and medical nutrition therapy.

   Needed skilled services shall be provided on-site in the facility. The rehabilitation services include:
   - physical therapy,
   - occupational therapy,
   - speech-language pathology services
   - rehabilitation services may be provided off-site*

   AND,

2. Member requires supervision / cueing in **at least three** of the following ADLs: **bathing** (documented along with rationale), **dressing** (must be assistance with upper and lower dressing to be considered 1 ADL), **toilet use, transfer, locomotion, and eating**. In addition, the following criteria must be met.
   - Facility will provide all of the supervision/cueing for the claimed ADLs on-site in the facility; **AND,**
   - Member exhibits problems with short-term memory; **AND,**
   - 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.**

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

NOTE: Skilled service means a needed skilled service provided by an RN or LPN, including, but not limited to:
   - Oxygen need;
   - Ostomy care;
   - 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**);
   - Wound treatment;
   - Stasis ulcer treatment;
   - Intravenous or intramuscular injection;
   - Nasogastric or gastrostomy tube feeding; and
   - Medical nutrition therapy.
3. 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:
     a. 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;

   AND,

   b. 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.

   AND,

   c. 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:
     • Discharge the member pursuant to N.J.A.C. 8:43F; OR,
     • 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.

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

(a) 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 (b) below, to:

1. The facility to which the member chooses to request to transfer; OR,
2. The member’s care manager if the member is a participant of any program listed at N.J.A.C. 8:86-1.1(b) that requires care management.

(b) 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; AND,
2. The name of the ADHS facility at which the member is receiving ADHS; AND,
3. The valid reason(s), as identified at (c) below, upon which the requestor bases the transfer request; AND,
4. The name of all ADHS facilities the member has attended, including dates attended; AND,
5. The signature of the member and/or the member’s legally authorized representative.

(c) 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;
   i. 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;
   i. A request to transfer based on this reason shall describe the nature of the violation; or
4. The transfer is medically necessary as identified by the member's attending physician, physician assistant, or advanced practice nurse;
   i. 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.

(d) 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 chooses to request to transfer with written notification providing the number of days per week the member may receive ADHS pursuant to N.J.A.C. 8:86-1.3(a)3 and 1.4(a)3.

(e) Upon receipt of a member’s written transfer request and, if applicable pursuant to (d) above, 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 (a)2 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. 8:86-1.3(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 and Community Services
New Jersey Department of Health and Senior Services
PO Box 807
Trenton, NJ 08625-0807

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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.

(f) Within 30 days of the date the Department receives the written transfer request, the Department shall take one of the actions specified in 1 through 4 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:

1. Approve a transfer request that presents at least one of the valid reasons provided at (c) above;
2. Approve a transfer request that does not present one of the valid reasons provided at (c) 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;
3. Deny a transfer request that does not present one of the valid reasons provided at (c) 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 (f)2 above; or
4. Request additional information if the written transfer request does not provide the requisite information identified at (b) above.

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

To receive benefits for the adult day services program for persons with Alzheimer’s disease or related disorders, members must be eligible for adult day services under the Adult Day Services Program for Persons with Alzheimer's Disease or Related Disorders (§ 8:92-6.1), and meet the following criteria:

- 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; AND,
- Be a resident of New Jersey; AND,
- Be routinely cared for by a family member or informal caregiver who does not receive financial remuneration for the care; AND,
- Reside in the community with a relative or informal caregiver; AND,
- 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; AND,
- Have income that falls within the income limits established in N.J.A.C. 8:92-3.2(c).

Priority shall be given to those members in moderate to severe ranges of disability. The scope of services or required services for members with Alzheimer's Disease or a Related Disorder shall include (§ 8:92-4.1):

- 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.
- 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.
- 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.
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.

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.

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)

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.

* 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. 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.

** 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 called for. In that case, a 510(k) will be the route to market (FDA, 2014). Products requiring PMAs are Class III devices are 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. (FDA, 2014).

** Medically Complex Child means a child who exhibits a severity of illness that requires ongoing skilled nursing intervention.

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.

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. (§ 8:87-5.1 General provisions). 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.
Pediatric Medical Day Care (PMDC) for pediatric members is considered medically necessary when the following criteria are met.

1. The initial functional assessment shall consist of the following:
   - An interview with the Medicaid member's parent(s); AND,
   - Observation of the Medicaid member; AND,
   - 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; AND,
   - 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 enteral 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; AND/OR,
     h. The need for intermittent bladder catheterization;
   - AND,

2. A detailed review of all other elements of the Medicaid member's care needs during a typical 24-hour period, including a review of:
   - Who provides care to the member; AND,
   - The types of care the member receives; AND,
   - The locations at which the member receives each type of care; AND,
   - 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;
   - AND,

3. 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;
   - AND,

4. A review of the family composition, ages of any siblings residing with the Medicaid member and the available community support.
   - AND,

5. 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:
   - Medicaid member identification information, including name, date of birth, gender, address, telephone number and Medicaid identification number; AND,
   - A narrative of the Medicaid member's current medical status, past medical history and any additional
considerations; AND,
  - 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; AND,
  - 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.

AND,

6. Professional staff designated by the State shall perform the functional assessment (New Jersey Choice Tool):
  - Prior to initial provision of services to a Medicaid member; AND,
  - When the interdisciplinary plan of care reflects a change in status that may alter a PMDC member's eligibility to receive PMDC; AND,
  - At least every 180 days after the initial and each subsequent assessment.

CODING

CPT® Codes – No applicable codes.
92507 Speech-language pathology services
97799 Unlisted physical medicine/rehabilitation service or procedure

HCPCS Codes
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

HCPCS Level III Codes
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
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

ICD-10- Procedure Code
Z21 Asymptomatic human immunodeficiency virus [HIV] infection status
B20 Human immunodeficiency virus [HIV] disease
A81.01 Variant Creutzfeldt-Jakob disease
A81.09 Other Creutzfeldt-Jakob disease
A52.17 General paresis
E75.4 Neuronal ceroid lipofuscinosis
E75.21 Fabry (-Anderson) disease
E75.23 Krabbe disease
E75.25 Metachromatic leukodystrophy
E75.29 Other sphingolipidosis
E75.00 GM2 gangliosidosis, unspecified
E75.02 Tay-Sachs disease
E75.09 Other GM2 gangliosidosis
E75.19 Other gangliosidosis
E75.5 Other lipid storage disorders
E75.6 Lipid storage disorder, unspecified
E77.1 Defects in glycoprotein degradation
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<td>Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus</td>
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<td>G40.111</td>
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<td>G40.119</td>
<td>Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus</td>
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ADULT AND PEDIATRIC
DAY HEALTH SERVICES
(MEDICAL DAY CARE) (NEW JERSEY)
HS-254

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES


Clinical Coverage Guideline


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**MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS**

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<td>10/5/2017, 12/8/2016</td>
<td>Approved by MPC. Included revisions from the market.</td>
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<td>6/2/2016, 5/7/2015</td>
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<tr>
<td>6/30/2014</td>
<td>Approved by MPC. Clarification of language.</td>
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