Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Child Care Services for Members Enrolled in Tufts Health Plan's Healthy Birthday Program

Effective: September 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 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

This guideline is used to determine coverage of childcare services for participants enrolled in Tufts Health Plan's Healthy Birthday Program.

Clinical Guideline Coverage Criteria

The Plan may authorize childcare services for Members meeting **ALL** of the following:

1. Pregnant Member actively participating in Tufts Health Plan's Healthy Birthday program
2. Current order from the obstetrical provider for **complete** bedrest at home (being up for meals and bathroom privileges only) because of a pregnancy-related complication, **AND**
    a. All family and community resources to provide childcare have been exhausted
    b. The Member would otherwise be unable to follow the physician's plan of care

Note: When childcare services are authorized the following apply:

1. The childcare benefit will be authorized for up to one month with requests for extensions reviewed by Tufts Health Plan case management on a case-by-case basis

2. The Member will be responsible for obtaining the childcare provider of their choice
3. The maximum allowance for the childcare provider will be up to $250.00 per week
4. Tufts Health Plan may randomly audit any and all childcare reimbursement claims/receipts

Limitations

The Plan will not continue reimbursement for authorized childcare services when:

1. The Member is no longer covered by Tufts Health Plan
2. The Member is hospitalized for greater than 48 hours
3. The Member is no longer on complete bed rest
4. The Member reaches 37 weeks gestation
5. The Member has delivered

Approval And Revision History

June 17, 2020: Reviewed by the IMPAC, renewed without changes

Subsequent endorsement date(s) and changes made:

- June 24, 2020: Fax number for Unify updated
- June 16, 2021: Reviewed by IMPAC, renewed without changes
- February 17, 2022: Freedom removed from template
- July 20, 2022: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- July 19, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Unify name changed to One Care effective January 1, 2024
- August 30, 2024: Reviewed by MPAC, renewed without changes, HPHC commercial unchecked as this benefit does not apply to Harvard Pilgrim
- September 17, 2025: Reviewed by MPAC, renewed without changes; Fax number for Senior Care Options, Tufts
- Medicare Preferred HMO and Tufts Medicare Preferred PPO updated; language for Carelink removed; Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template, effective November 1, 2025
- July 15, 2026: Reviewed by MPAC for annual review, renewed without changes effective September 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.