Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines: **Home-Based Therapeutic Services (HBTS)**

Effective: January 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

Home-based therapeutic services (HBTS) are intensive outpatient services within the continuum of care for children and adolescents with special health care needs. HBTS is intended for children and adolescents with moderate to severe special health care needs who experience chronic developmental, cognitive, physical, medical, neurological, behavioral and/or emotional conditions, and whose level of functioning is significantly compromised. The services are intended to meet the needs of the children to attain their fullest potential and to remain as independent as possible within their communities. The Members' health and well-being requires a type and amount of services that exceeds their typically developing peers. Tufts Health RITogether must provide these services to any Medicaid Member under age 21, per federal EPSDT regulation.

HBTS is a phased system approach that includes in person, high frequency, specialized treatment and supervision of direct care staff. The services are provided for children with complex health needs in a holistic, person-and family centered manner; those living at home or in foster care (not specialized DCYF foster care) and delivered in a child's home, community or outpatient setting. Services are provided to improve Member outcomes by integrating social, behavioral health, and physician health needs. HBTS is a medically necessary treatment and not to provide companionship for child/adolescent or Respite for family.

The HBTS level of care requires frequent contact with the child/adolescent and parents/caregivers/ guardians engaged in treatment. Treatment is often several hours per day throughout the course of a week. Services may be combined with other outpatient therapies, supports, or education services, but is not to be used as a replacement for other required/recommended therapies.

Note: *Although applied behavioral analysis (ABA) is a HBTS service, there is a separate MNG for ABA Therapy for Autism Spectrum Disorders.*

Clinical Guideline Coverage Criteria

Admission Coverage Criteria

The Plan considers admission for home-based therapeutic services as reasonable and medically necessary when **ALL** of the following are met:

1. Member is less than 21 years of age; **and**
2. The child has a diagnosis and demonstrates symptoms and behavior consistent with a DSM or corresponding ICD psychiatric, medical, or developmental diagnosis made by a licensed health care professional with competence in child psychology child psychiatry, or child development; **and**
3. A less intensive level of care would not be appropriate to meet the Member's needs nor would a more intensive level or care; **and**
4. The child presents with moderate to severe and potentially chronic (12 months or longer in experienced or expected duration) medical and/or physical condition(s) that require intensive therapeutic intervention. The condition(s) manifest impairments that substantially interferes with or limits the Member's role or functioning in family, school or community activities in **two** or more of the following areas:
    a. Cognitive functioning: intellectual disability or intellectual developmental disorder.
    b. Problem solving functioning: judgment, insight, reasoning, impulse control, and/or learning.
    c. Adaptive skills: communication/speech, dressing, eating, sleeping, or social relatedness.
    d. Regulation of mood: marked instability of mood (e.g., irritability, depression, anxiety, or mania).
    e. Functional impairments related to medical/neurological condition.
5. Outpatient services provided at an intensified level have not been sufficient due to the child's special health care needs. (This does not preclude from consideration the role of family therapy or other supports for a family that may be seeking HBTS.) ; **and**
6. The child and parent/guardian require support in order for the child to remain stable outside of an inpatient environment, or to transition to independent living from a more restrictive setting; **and**
7. The child and parent/guardian are willing to accept and cooperate with HBTS, and agree to be active participants at the level outlined in the HBTS Treatment plan; **and**
8. Member has the capacity to make significant progress towards treatment goals and has the ability to reasonably respond and participate in treatment; **and**
9. Home environment does not pose a safety threat to HBTS staff or there are identified alternative community settings likely to ameliorate the risk.

Continuation Coverage Criteria

The Plan considers the continuation of home-based therapeutic services as reasonable and medically necessary when **ALL** of the following are met:

1. Member continues to meet admission criteria and another level of care is not appropriate; **and**
2. Evidence suggests that the identified problems will respond to current treatment plan; **and**
3. Parent/guardian continues to require HBTS services in order to improve his/her ability to parent; **and**
4. Treatment is focused on the child and parent/guardian's need for support, guidance, and coaching; **and**
5. All services and supports are tied to achievable measurable goals within a specified timeframe; **and**
6. Member and parent/guardian progress toward goals is monitored regularly. The treatment plan is modified if Member and/ or parent/guardian is not making substantial progress; **and**
7. Progress to specific behaviors, symptoms, or impairments is evident and can be described in objective terms, but:
    a. Goals have not yet been reached, or
    b. Adjustments in the treatment plan to address lack of progress are present
8. Frequency of treatment is consistent with the severity of current symptoms; **and**
9. Evidence exists that Member is at current risk for more restrictive level of care if treatment is discontinued; **and**
10. Coordination of care and active discharge planning are occurring.

Discharge Coverage Criteria

The Plan considers the termination of home-based therapeutic services as reasonable and medically necessary when **ONE** of the following is met:

1. Treatment Plan goals and objectives have been substantially met and continued services are not necessary; **or**

2. Member no longer meets admission criteria and/or meets criteria for another level of care; **or**
3. Consent for treatment has been withdrawn by a youth 18 or older, or his/her parent(s) or legal guardian(s) ; **or**
4. Member/parent/guardian is not making progress toward the goals and there is no reasonable expectation of progress with the current treatment plan; **or**
5. Parent/guardian is not engaged in the service to such a degree that this service is effective or safe, despite multiple, documented attempts to remediate; **or**

Limitations

HBTS is not intended to replace clinically necessary therapies such as behavioral health treatment including emergency treatment, psychiatric care, speech and language therapy, occupational or physical therapy. HBTS represent an integrated set of service components with measurable goals and objectives written and approved by a licensed health care professional[1].

In some instances, the following criteria may also apply:

- The child may be at risk for hospitalization(s) or out-of-home placement without eventual use of HBTS. HBTS is not intended to serve as emergency care and referrals do not provider immediate access. HBTS may not be provided when child and adolescent intensive treatment services (CAITS), child and family intensive treatment (CFIT) or enhanced outpatient services (EOS) are being used[2].

Exclusions

Any of the following criteria are sufficient for exclusion from this level of care:

1. The Member requires a level of structure and supervision beyond the scope of HBTS.
2. The Member has medical conditions or impairments that would prevent beneficial utilization of services.
3. The Member is living in a specialized foster care setting through DCYF.

Codes

The following code(s) are associated with this service:

Table 1: CPT/HCPCS Codes

Code	Description
T1024	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter
T1027	Family training and counseling for child development, per 15 minutes
H2014	Skills training and development, per 15 minutes
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	Community psychiatric supportive treatment program, per diem
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
H2016	Comprehensive community support services, per diem
H2021	Community-based wrap-around services, per 15 minutes
H2022	Community-based wrap-around services, per diem
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	Community psychiatric supportive treatment program, per diem
H0039	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive community treatment program, per diem
H2015	Comprehensive community support services, per 15 minutes
H2016	Comprehensive community support services, per diem
T1040	Medicaid certified community behavioral health clinic services, per diem
T1041	Medicaid certified community behavioral health clinic services, per month

[1] State of Rhode Island, EOHHS Certification Standards Providers of Home Based Therapeutic Services (inclusive of ABA), January 1, 2016, Page 6.
[2] State of Rhode Island, EOHHS Certification Standards Providers of Home Based Therapeutic Services (inclusive of ABA), January 1, 2016, Page 12.

References:

1. State of Rhode Island Executive Office of Health and Human Services, Certification Standards, Providers of HBTS (Inclusive of ABA), January 1, 2016, accessed January 4, 2024.
2. Solicitation Information, July 14, 2016 for Medicaid Managed Care Services, Attachment 4, Model Contract, Attachment O, Mental Health, Substance Use and Developmental Disabilities Services for Children.

Approval And Revision History

October 21, 2020: Reviewed by the Medical Policy Approval Committee (MPAC) and renewed without changes

Subsequent endorsement date(s) and changes made:

- November 4, 2020: Fax number for Unify updated
- September 15, 2021: Reviewed by IMPAC, renewed without changes
- April 6, 2022: Template updated
- September 21, 2022: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- April 19, 2023: Reviewed by Medical Policy Approval Committee (MPAC), Removal of codes T1028 and T1023 from policy. Prior authorization of these codes removed effective April 19, 2023.
- August 16, 2023: Reviewed by MPAC, renewed without changes, template updated effective November 1, 2023
- December 20, 2023: Reviewed by MPAC. Removal of codes G0151, G0152, G0153, G0159, G0160 and G0161, from the guideline. Removal of Prior authorization from this service as directed by RI EOHHS. MNG will remain as a no PA Policy effective February 1, 2024.
- September 19, 2024: Reviewed by MPAC, renewed without changes effective November 1, 2024
- November 19, 2025: Reviewed by MPAC for annual review, renewed without changes effective January 1, 2026
- December 2025: Administrative updates effective January 1, 2026
- March 16, 2025: Administrative updates, title of MNG changed to “Home-Based Therapeutic Services (HBTS)”

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