Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines

Home Accessibility Adaptations

Effective: August 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.

Overview

Home Accessibility Adaptations are physical modifications to the member's home that are necessary to ensure the health, welfare, and safety of the member or that enable the member to function with greater independence in the home as defined by the Commonwealth of Massachusetts Program Regulations for Home- and Community- Based Services, 130 CMR 630.000. A home modification can help a member to remain in their own home. Some examples of Home Accessibility Modifications include improved entryways, an egress into a home (i.e., ramps), or configuring a bathroom to accommodate a wheelchair. Home Accessibility Adaptations can also be included under Transitional Services which is defined as nonrecurring residential set-up expenses for Member's who are transitioning from a nursing facility or hospital to a community living arrangement where the Member is directly responsible for their own set-up expenses. Allowable expenses are those that are necessary to enable a person to establish a basic household and do not constitute Room and Board.

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations where available. For The Plan, the following criteria is used: 130 CMR 630.000: Home – and Community-Based Services waiver Services

Clinical Guideline Coverage Criteria

The Plan considered Home Accessibility Adaptations as reasonable and medically necessary when **ALL** of the following are met:

1. The provider must be qualified to perform environmental and minor home adaptions in accordance with applicable

state and local building codes, and comply with an applicable registration or license requirements; **and**

2. The provider must be under contract with Massachusetts Rehabilitation Commission (MRC) in accordance with its standards, requirements, policies, and procedures from the provision of home accessibility adaptation; **and**
3. Home Accessibility Adaptations are included in the service plan for the Member; **and**
4. The Member is unable to reside in their home without the accessibility adaptions; **and**
5. The home adaptions will enable the Member to function with greater independence within their own home; **and**
6. All home accessibility adaptions must be provided in accordance with applicable state and local building codes; **and**
7. If the Member is part of transitional services, they must have **ALL** of the following:
    a. As part of their discharge from a nursing facility or hospital to the community a home accessibility adaptation is needed for the Member to live independently; **and**
    b. The adaptation is authorized and included in the Member's transition plan; **and**
    c. The adaptation is incurred within 180 days before the Member's discharge from a nursing facility or hospital or another provider- operated living arrangement or during the period following discharge from the facility; **and**
    d. The adaptation is necessary for the Member's safe transition to the community

Note: MRC is responsible for paying providers for transitional assistance services

Limitations

1. The Plan will not cover cost of maintenance, upkeep, an improvement, or home accessibility to a residential habilitation site, group home, or other provider- owned and operated residential setting
2. The Plan will not cover cost of maintenance, upkeep, an improvement to a Member's place of residence, except for home accessibility adaptations in accordance with the above criteria
3. Home accessibility adaptations are not covered for **ANY** of the following:
    a. When the adaptation brings a substandard dwelling up to minimum standards or to make improvements to a residence that are of general utility and are not of direct medical or remedial benefit to the Member
    b. Are required by law to be made by a landlord or other third party
    c. Add to the total square footage of the home, except when necessary to complete an adaptation (for example, in order to improve entrance and egress to a residence or to configure a bathroom to accommodate a wheelchair)
    d. The services is not necessary as part of the Member's safe transition to the community

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
S5165	Home modification, per service

References:

1. 130 CMR 630.000: Home – and Community-Based Services waiver Services, 2025. Accessed April 9, 2026. https://www.mass.gov/doc/home-and-community-based-services-waivers-regulations-1/download

Approval And Revision History

August 16, 2023: Reviewed by the Medical Policy Approval Committee (MPAC) effective January 1, 2024

Subsequent endorsement date(s) and changes made:

- November 2023: Unify name changed to One Care effective January 1, 2024
- October 17, 2024: Reviewed by MPAC, renewed without changes effective December 1, 2024
- August 20, 2025: Reviewed by MPAC, renewed without changes effective October 1, 2025
- September 5, 2025: Fax number for Senior Care Options, Tufts Medicare Preferred HMO and Tufts Medicare Preferred PPO updated; language for Carelink removed
- December 8, 2025: Reviewed by UM Committee, removed One Care as an appliable line of business, service moved

under Flexible Benefit MNG effective January 1, 2026
- December 17, 2025: Reviewed by MPAC, removed One Care as an appliable line of business, service moved under Non-Covered Home and Community Based Service-Flexible Benefits Tufts Health One Care MNG effective January 1, 2026
- June 15, 2026: Reviewed by UM Committee, renewed without changes effective August 1, 2026
- June 17, 2026: Reviewed by MPAC, renewed without changes effective August 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.