Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines: **In Home Therapy Services – Massachusetts Products**

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

In-Home Therapy Services: This service is delivered by one or more Members of a team consisting of professional and paraprofessional staff, offering a combination of medically necessary In-Home Therapy and Therapeutic Training and Support. The main focus of In-Home Therapy Services is to ameliorate the youth's mental health issues and strengthen the family structures and supports. In-Home Therapy Services are distinguished from traditional therapy in that services are delivered in the home and community; services include 24/7 urgent response capability on the part of the provider; the frequency and duration of a given session matches need and is not time limited; scheduling is flexible; services are expected to include the identification of natural supports and include coordination of care.

Coverage for services is available to children and adolescents that meet the following medical necessity criteria until the Member's 19th birthday. Tufts Health Plan will continue coverage for services for Members age 19 and beyond when services are medically necessary and part of an ongoing treatment plan.

In-Home Therapy is situational, working with the youth and family in their home environment, fostering understanding of the family dynamics and teaching strategies to address stressors as they arise. In-Home Therapy fosters a structured, consistent, strength-based therapeutic relationship between a licensed clinician and the youth and family for the purpose of treating the youth's behavioral health needs, including improving the family's ability to provide effective support for the youth to promote his/her healthy functioning within the family. Interventions are designed to enhance and improve the family's capacity to improve the youth's functioning in the home and community and may prevent the need for the youth's admission to an inpatient hospital, psychiatric residential treatment facility or other treatment setting. The In-Home Therapy team (comprised of the qualified practitioner(s), family, and youth), develops a treatment plan and, using established

psychotherapeutic techniques and intensive family therapy, works with the entire family, or a subset of the family, to implement focused structural or strategic interventions and behavioral techniques to: enhance problem-solving, limit-setting, risk management/safety planning, communication, build skills to strengthen the family, advance therapeutic goals, or improve ineffective patterns of interaction; identify and utilize community resources; develop and maintain natural supports for the youth and parent/caregiver(s) in order to promote sustainability of treatment gains. Phone contact and consultation are provided as part of the intervention.

In-Home Therapy is provided by a qualified clinician who may work in a team that includes one or more qualified paraprofessionals.

Therapeutic Training and Support is a service provided by a qualified paraprofessional working under the supervision of a clinician to support implementation of the licensed clinician's treatment plan to assist the youth and family in achieving the goals of that plan. The paraprofessional assists the clinician in implementing the therapeutic objectives of the treatment plan designed to address the youth's mental health, behavioral and emotional needs. This service includes teaching the youth to understand, direct, interpret, manage, and control feelings and emotional responses to situations and to assist the family to address the youth's emotional and mental health needs. Phone contact and consultation are provided as part of the intervention.

In Home Therapy Services may be provided in any setting where the youth is naturally located, including, but not limited to, the home (including foster homes and therapeutic foster homes), schools, childcare centers, respite settings, and other community settings.

Clinical Guideline Coverage Criteria

Admission Criteria
The Plan considers initial In-Home therapy Services as reasonable and medically necessary when **ALL** of the following criteria are met:

1. A comprehensive behavioral health assessment indicates that the youth's clinical condition warrants this service in order to enhance problem-solving, limit-setting, and risk management/safety planning, communication; to advance therapeutic goals or improve ineffective patterns of interaction; and to build skills to strengthen the parent/caregiver's ability to sustain the youth in their home setting or to prevent the need for more intensive levels of service such as inpatient hospitalization or other out of home behavioral health treatment services; **and**
2. The youth resides in a family home environment (e.g., foster, adoptive, birth, kinship) and has a parent/guardian/caregiver who voluntarily agrees to participate in In-Home Therapy Services; **and**
3. Outpatient services alone are not or would not likely be sufficient to meet the youth and family's needs for clinical intervention/treatment; **and**
4. Required consent is obtained; **and**
5. The youth is under age 19.

Continuation Criteria
The Plan considers continuation of In-Home Therapy Services as reasonable and medically necessary when **ALL** of the following criteria are met:

1. The youth's clinical condition continues to warrant In-Home Therapy Services and the youth is continuing to progress toward identified, documented treatment plan goal(s); **and**
2. Progress toward identified treatment plan goal(s) is evident and has been documented based upon the objectives defined for each goal, but the goal(s) has not been substantially achieved; **or**
3. Progress has not been made and the In-Home therapy team has identified and implemented changes and revisions to the treatment plan to support the goals; **and**
4. The youth is actively participating in the treatment as required by the treatment plan/ICP to the extent possible consistent with his/her condition; **and**
6. The parent/guardian/caregiver is actively participating in the treatment as required by the treatment plan/ICP.

Discharge Criteria
The Plan considers the continuation of In-Home Therapy Services as not reasonable or medically necessary when **ANY** of the following criteria are met:

1. The treatment plan goals and objectives have been substantially met and continued services are not necessary to prevent worsening of the youth's behavioral health condition; **or**
2. The youth and parent/guardian/caregiver are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe; **or**

3. The youth is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is not ready for discharge to a family home environment or a community setting with community-based supports; **or**
4. Required consent for treatment is withdrawn; **or**
5. The youth is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is this level of care required to prevent worsening of the youth's condition.

**Please note that Psychosocial, Occupational, and Cultural and Linguistic factors may change the risk assessment and should be considered when making level-of-care decisions.*

Limitations

Coverage for services is available to children and adolescents that meet the foregoing medical necessity criteria until the Member's 19th birthday. Tufts Health Plan will continue coverage for services for Members age 19 and beyond when services are medically necessary and part of an ongoing treatment plan.

The Plan considers in-home therapy services as not reasonable or medically necessary if **ANY** of the following criteria are met:

1. Required consent is not obtained; **or**
2. The youth is in a hospital, skilled nursing facility, psychiatric residential treatment facility or other residential treatment setting at the time of referral and is not ready for discharge to a family home environment or community setting with community-based supports; **or**
3. The needs identified in the treatment plan that would be addressed by in-home therapy services are being fully met by other services; **or**
4. The environment in which the service takes place presents a serious safety risk to the In-Home Therapy Service provider, alternative community settings are not likely to ameliorate the risk and no other safe venue is available or appropriate for this service; **or**
5. The youth is in an independent living situation and is not in the family's home or returning to a family setting; **or**
6. The youth has medical conditions or impairments that would prevent beneficial utilization of services.

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
H2019	Therapeutic behavioral services, per 15 minutes

Please refer to the Inpatient and Intermediate Behavioral Health/Substance Use Disorders Facility Payment Policy, for more information regarding billing of these services.

References:

1. Commonwealth of Massachusetts, Executive Office of Health and Human Services, MassHealth criteria for coverage of In-Home Therapy Services. Accessed at mass.gov/files/documents/2016/07/qy/mnc-in-home-therapy-services.pdf, Last accessed October 4, 2024.

Approval And Revision History

October 21, 2020: Reviewed by IMPAC, 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 7, 2022: Template updated.
- September 21, 2022: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes.
- August 16, 2023: Reviewed by MPAC; renewed without changes, template updated effective November 1, 2023
- November 2023: Unify name changed to One Care effective January 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

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.