Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Long-Term Services & Supports (LTSS) for Tufts Health One Care

Effective: October 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☒ No ☐
Notification Required	Yes ☐ No ☒

Applies to:

- Tufts Health One Care

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

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.

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Overview

Long-term services and supports (LTSS) encompass a variety of health, health-related, and social services that assist individuals who lack the capacity for self-care due to physical, cognitive, or mental conditions or disabilities. LTSS includes assistance with activities of daily living (ADLs, such as eating, bathing, and dressing) and instrumental activities of daily living (IADLs, such as housekeeping and managing money) over an extended period of time. The goal of LTSS is to facilitate optimal functioning to allow Members to live with independence and dignity in their daily lives, participate in their communities, and increase their overall quality of life. This medical policy addresses Adult Day Health, Adult Foster Care, Day Habilitation, Group Adult Foster Care, and Personal Care Attendant Program.

Clinical Guideline Coverage Criteria

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 **Tuft's Health One Care** plan Members, the criteria below reflects the following MassHealth criteria: Adult Foster Care 130 CMR 408.000, 130 CMR 404.00: Adult day health services, 130 CMR 630.000: Home – and Community-Based Services waiver Services, 101 CMR 348.00: Day Habilitation Program Services, 130 CMR 450.000 Group Adult Foster Care Group Adult Foster Care and Manual for MassHealth Providers, and 130 CMR 422:00: Personal Care Services.

ADULT DAY HEALTH (ADH)

Adult day health services provide skilled nursing care, supervision, and health related support services in a structured community-based non-residential day setting. Members are able to receive assistance with their ADLs, nutritional and dietary services, counseling services, social /recreational and therapeutic activities, and social services case management while in attendance of the program. These services are designed to allow members to stay mentally and physically active, reduce isolation, monitor, and improve health and prevent decline of their abilities. ADH services are provided Monday through Friday and typically provided 6 hours per day.

The Plan may authorize the coverage of ADH services when **ALL** of the following criteria are met:

1. The Member requires services in a structured adult day health setting; **and**
2. The Member has one or more chronic or post-acute medical, cognitive, or mental health condition(s) identified by the Member's PCP that require active monitoring, treatment or intervention and ongoing observation and assessment by a nurse, without which the Member's condition will likely deteriorate; **and**
3. The Member requires **one or both** of the following be provided by the ADH program;
    a. At least one skilled service (as noted in 130 CMR 404.000 MA Adult Day Health regulation) ordered by a physician that falls within the professional disciplines of nursing, physical, occupational, and speech therapy; **or**
    b. At least daily or on a regular basis hands-on (physical) assistance or cueing and supervision, throughout the entire activity (as determined clinically appropriate by the ordering physician and the ADH program nurse developing the plan of care) with at least;
        i. **one or more** of the following ADLs when required at the ADH program to qualify for basic ADH services:
            - bathing—a full body bath or shower or a sponge (partial) bath which may include washing and drying of face, chest, axillae (underarms), arms, hands, abdomen, back and peri-area that may include personal hygiene such as combing or brushing of hair, oral care, shaving, and when applicable applying make-up; **or**
            - toileting: member is incontinent (bladder or bowel) or requires scheduled assistance or routine catheter or colostomy care; **or**
            - transferring: member must be assisted or lifted to another position; **or**
            - mobility (ambulation: member must be physically steadied, assisted or guided in mobility, or is unable to self-propel a wheelchair appropriately without the assistance of another person; **or**
            - eating: member requires constant supervision and cueing during the entire meal or physical assistance with a portion or all of the meal); **or**
        ii. **3 or more** of the ADLS listed above to quality for complex ADH services

Note: Prior authorization requests for Adult Day Health (ADH) services must contain the following information:

1. The Member's level of care: basic or complex
2. Clinical assessment (MDS) completed by the Adult Day Health (ADH) program that has been conducted prior to admission, on an annual basis or upon a significant change
3. A PCP order form for Adult Day Health (ADH) services
4. The Member's Adult Day Health (ADH) care plan

Limitations

The Plan does not cover ADH services when:

1. The Member is a resident or at an inpatient status at a hospital, nursing facility, or intermediate care facility for people with intellectual disabilities.
2. Examples of services that are considered duplicative of ADH and thus cannot be provided concurrent with the provision of ADH services include, but not limited to:

a. Services provided by a Home Health Agency while the Member is in attendance at the ADH program
b. PCA services provided during the time the Member is at the ADH program
c. Companion services
d. Skilled services, such as medication management

ADULT FOSTER CARE (AFC)

AFC is a service that is delivered to a Member in a qualified setting within the community. It is provided by a multidisciplinary team and a qualified Adult Foster Care (AFC) caregiver, who lives in the residence and is responsible for the 24-hour supervision and assistance with ADLs, Instrumental Activities Of Daily Living (IADLs) and any other personal care as needed. The Adult Foster Care (AFC) services caregiver is selected, supervised, and paid by the Adult Foster Care (AFC) provider. A Member receiving AFC services may live in their own home with an AFC caregiver or may live in the home of their AFC caregiver, who provides the AFC services. The program is under the supervision of a registered nurse and the multi-disciplinary team (including AFC care management) in accordance with each Member's written plan of care.

The Plan may authorize the coverage of AFC services when **ALL** of the following criteria are met:

1. The Member's PCP has ordered AFC; **and**
2. AFC care will be delivered by a qualified AFC caregiver; **and**
3. Documentation (including clinical assessment) and plan of care supports the Member's clinical status and need for or continuation of AFC; **and**
4. The Member has a medical or mental condition that requires daily hands-on physical assistance or cueing and supervision throughout the entire activity in order for the Member to successfully complete, **One**:
    a. **at least one** of the following activities **for AFC Level I Service**:
        i. Bathing: A full-body bath or shower or a sponge (partial) bath that may include washing and drying of face, chest, axillae (underarms), arms, hands, abdomen, back and peri-area plus personal hygiene that may include the following: combing or brushing of hair, oral care (including denture care and brushing of teeth), shaving, and, when applicable, applying make-up; **or**
        ii. Dressing: upper and lower body, including street clothes and undergarments, but not solely help with shoes, socks, buttons, snaps, or zippers; **or**
        iii. Toileting: The Member is incontinent (bladder and/or bowel), or requires routine catheter or colostomy/urostomy care, or needs cueing and supervision or physical assistance with toileting and cleansing after elimination; **or**
        iv. Transferring: Member must be assisted or lifted to another position; **or**
        v. Mobility (ambulation): The Member must be physically steadied, assisted, or guided during ambulation, or is unable to self -propel a wheelchair appropriately without the assistance of another person; **or**
        vi. Eating: The Member requires constant supervision and cueing during the entire meal or needs to be physically assisted in eating (fed) for all or a portion of the meal. Members who are physically capable of eating but have a cognitive impairment that requires constant cueing and supervision to eat are deemed to require assistance with eating. Members needing help only with cutting up food or other set-up do not require assistance with eating.

    AFC Level II Service

    b. **at least daily hands-on physical assist with three ADLs** described above; **or**
    c. **at least daily hands-on physical assist with two ADLs** described above **AND** management of **one** behavior that requires frequent caregiver intervention as described below:
        i. Wandering: moving with no rational purpose, seemingly causing general disruption, including difficulty in transitioning between activities; **or**
        ii. Verbally Abusive Behavioral Symptoms: threatening, screaming, or cursing at others; **or**
        iii. Physically Abusive Behavioral Symptoms: hitting, shoving, or scratching; **or**
        iv. Socially Inappropriate or Disruptive Behavioral Symptoms: disruptive sounds, noisiness, screaming, self-abusive acts, disrobing in public, smearing, or throwing food or feces, rummaging, repetitive behavior, or causing general disruption; **or**
        v. Resisting Care: refusing care (physically or verbally) or interfering with assistance.

Note: Prior authorization requests for Adult Foster Care (AFC) services must contain the following information:

1. The Member's level of care: Level 1 or Level 2
2. A clinical assessment (MDS) completed by the Adult Foster Care (AFC) that has been conducted prior to admission,

on an annual basis, upon a significant change or upon transfer from one Adult Foster Care (AFC) provider to another Adult Foster Care (AFC) provider

3. A PCP order form for Adult Foster Care (AFC) services
4. The Member's Adult Foster Care (AFC) care plan

Limitations

The Plan does not cover AFC services when:

1. The Member is a resident or at an inpatient status of a hospital, nursing facility, or intermediate facility for people with intellectual disabilities
2. The live-in caregiver cannot be a legally responsible relative (i.e. spouse of the Member or parent of a minor Member
3. Examples of services that are considered duplicative of AFC and thus cannot be provided concurrent with the provision of AFC services include, but not limited to:
    a. Personal Care Assistance services (PCA, PC, HHA)
    b. Group Adult Foster Care services

DAY HABILITATION (DH)

Day habilitation services are provided in a community-based setting for Members with intellectual or developmental disabilities who have skilled needs and/or who could benefit from a structured day program that promotes and facilities independent living and self-management in the community. Day habilitation programs typically run 6 hours per day and are provided Monday through Friday. Services are based on a day habilitation service plan that may include skilled nursing services and health care supervision, developmental skills training (including self-help development, sensorimotor development, communication development, social development, independent living development, affective development skills, behavior development, and wellness), therapy services (including PT, OT, ST, and behavior management), and assistance with ADLs. Members can be authorized for Day Habilitation (DH) services for up to 2 years.

The Plan may authorize the coverage of DH services in an outpatient setting when **ALL** of the following criteria are met:

1. All Members, except those who are residents of an NF, must meet the following clinical eligibility criteria for receipt of DH:
    a. The Member is under the care of a physician; **and**
    b. The Member has an intellectual **or** developmental disability as defined by MassHealth in 130CMR 419.402 and certified by a primary care physician:
        i. Intellectual Disability (ID) – significant limitations in both intellectual functioning and adaptive behavior as expressed in conceptual, social, and practical skills and that originates before the individual reaches 22 years of age; **or**
        ii. A severe, chronic disability that
            - is attributable to other conditions found to be closely related to ID, apart from mental illness, which results in the impairment of general intellectual functioning or adaptive behavior similar to that of persons with ID, and which requires treatment or services similar to those required for such persons; **and**
            - is manifested before a person reaches 22 years of age; **and**
            - is likely to continue indefinitely; **and**
            - results in substantial functional limitations in **three or more** of the following major areas:
                - self-care;
                - understanding and use of language;
                - learning;
                - mobility;
                - self-direction;
                - capacity for independent living; **and**
    c. Documentation of the need for DH for the Member to acquire, improve, or retain their maximum skill level and independent functioning

Note: **Day Habilitation will now follow MassHealth's Interim Prior Authorization (PA) guidance. This PA is a temporary PA covering a period of 60 calendar days which is automatically adjudicated based on the providers' initial assessment of the Member's needs. This temporary authorization allows for services to be delivered while required assessments are completed. Therefore, prior authorization is not required for the first 60 calendar days for this service. See coding instructions below to submit for Interim PA for Day Habilitation.**

Prior authorization requests for Day Habilitation (DH) services must contain the following information:

1. The Member's Day Habilitation (DH) level of care: low need, moderate need, high need (Level I, 2, 3 or 4)
2. A clinical assessment performed by the Day Habilitation (DH) provider that confirms the following:
    a. The Member has a physical examination or wellness visit by a PCP within 12 months before the start of DH service;
    b. The Member has had a comprehensive Service Needs Assessment (SNA)* by a referring entity that includes a written assessment of the Member's functional level, needs, and strengths addressing each of the following need areas: self-help skills, sensorimotor skills, communication skills, independent living skills, affective development skills, social development skills, behavioral development skills, and wellness;
3. Day Habilitation (DH) service plan that addresses the specific recommendations/plan to address acquisition, improvement, or maintenance of each identified need area for the member.

*__Note__: A Service Needs Assessment must be completed within 45 business days of a member's admission and every two years thereafter and upon a significant change in the member's condition.

Limitations

The Plan does not cover DH services when:

1. The Member is a resident or at an inpatient status at a hospital, nursing facility, or intermediate care facility for people with intellectual disabilities, except if the service is recommended as a specialized service pursuant to PASRR
2. Services that are considered duplicative of DH and thus cannot be provided concurrently with the provision of DH services include:
    a. PCA services provided during the time the Member is at the DH site
    b. HHA Services provided during the time the Member is at the DH site

GROUP ADULT FOSTER CARE (GAFC)

Group Adult Foster Care (GAFC) services provide assistance with ADLs and IADLs up to 2 hours per day, on a daily basis to members living in an assisted living residence (ALR) or an elderly/disabled housing complex within the community. Members appropriate for GAFC may include, but are not limited to the following: individuals who currently reside in the community or are hospitalized and are at high risk of requiring nursing home placement; patients discharged from nursing homes, and chronically disabled individuals who require supervision. Members receive oversight of their care from a registered nurse and social worker/care manager through the GAFC provider. Members can be authorized for GAFC services for up to 1 year.

The Plan may authorize the coverage of GAFC services when **ALL** of the following criteria are met:

1. The service is physician ordered/approved; **and**
2. The Member is capable of participating in the program: **both**
    a. Member can communicate his/her needs (is oriented to time, place and person but may have periods of confusing or forgetfulness); **and**
    b. Member does not exhibit behavior harmful to his/herself or others; **and**
3. The Member requires daily assistance with **at least one** of the following ADLS:
    a. Mobility/Transfers; **or**
    b. Taking Medications; **or**
    c. Bathing & Grooming; **or**
    d. Dressing & Undressing; **or**
    e. Eating; **or**
    f. Toileting; **and**
4. The Member may benefit from some ADL assistance at home, but generally does not require more than 2 hours a day of ADL support.

Note: Prior authorization requests for GAFC services must include the following information:

1. A clinical assessment (MDS) completed by the Group Adult Foster Care (GAFC) provider
2. A physician summary
3. The Member's Group Adult Foster Care (GAFC) care plan

LIMITATIONS:

The Plan does not cover GAFC services when:

1. The Member is a resident or at an inpatient status at a hospital, nursing facility, or intermediate care facility for people with intellectual disabilities or certain other residential facilities subject to state licensure or certification.
2. Services that are considered duplicative of GAFC and thus cannot be provided concurrent with the provision of GAFC include:
    a. Personal Care Assistance services (PC, PCA, HHA)
    b. AFC services

PERSONAL CARE ATTENDANT (PCA)

Personal Care Attendant (PCA) services are a self-directed program that allows members and/or their surrogate (if applicable) to recruit, hire, train and supervise a PCA that provides physical assistance with the Member's ADLs and IADLs. The Member can choose their PCM from the list of available PCMs in their geographical area. PCA services are often provided in the Member's home, but may be provided elsewhere in the community at the direction of the Member. A clinical evaluation helps to determine the need for PCA services and the hours of physical assistance that a member requires. For Members residing with a spouse or family members, it is expected that they provide assistance with IADLs rather than the PCA. PCA services also work with a fiscal intermediary provider that perform employer and payroll related administrative tasks. Members can be authorized for Personal Care Attendant (PCA) services for up to 1 year.

The Plan may authorize the coverage of PCA services when **ALL** of the following criteria are met:

1. The Member's disability is permanent or chronic in nature and impairs the Member's functional ability to perform ADLs and IADLs without physical assistance; **and**
2. The Member requires physical assistance with **two or more** of the following ADLs*:
    a. mobility: physically assisting a member who has a mobility impairment that prevents unassisted transferring, walking, or use of prescribed durable medical equipment;
    b. assistance with medications or other health-related needs: physically assisting a member to take medications prescribed by a physician that otherwise would be self- administered;
    c. bathing or grooming: physically assisting a member with bathing, personal hygiene, or grooming;
    d. dressing: physically assisting a member to dress or undress;
    e. passive range-of-motion exercises: physically assisting a member to perform range-of motion exercises;
    f. eating: physically assisting a member to eat. This can include assistance with tube feeding and special nutritional and dietary needs; **and**
    g. toileting: physically assisting a member with bowel or bladder needs.

Personal Care Attendant- Meal Preparation

Meal preparation time applies only to food prepared for oral consumption. Per MassHealth regulation 130 CMR 422.410(C)(3), a maximum of **7** hours per week will not require prior authorization. Authorization of any time beyond 7 hours per week will require prior authorization and therefore require a demonstration of medical necessity to support the request.

The Plan may authorize the coverage of additional PCA meal preparation hours when **ALL** of the following criteria is met:

1. The Member has an active diagnosis of dysphagia; **and**
2. The Member has a need for mechanically altered meals; **and**
3. The Member has the following clinical documentation that supports this diagnosis and needs:
    a. Clinical documentation must align with timeline requirements for all evaluation/PA requests; **and**
    b. Clinical documentation should describe functional swallowing limitations and identify any risk factors such as aspiration or choking; **and**
    c. Clinical documentation clearly distinguishes meals requiring preparation for oral intake from g-tube feeding tasks.[10]

If the Member is eligible for time greater than 7 hours per week based on the above criteria, the PCM will need to request the additional time in the evaluation that aligns with the specific type of mechanical alteration outlined in the Personal Care Attendant Program Operating Standards Document.

Note: For Consumers who get nutrition via g-tube and by mouth, the clinical evaluator must clearly demonstrate in the evaluation the need for regular/scheduled meal prep needs for non-g-tube delivered meals. G-tube feeding activities, including setup, administration, and cleanup, are considered complex care tasks and are not counted toward meal preparation time. Duplicate or overlapping time for meal preparation and g-tube feeding tasks will not be authorized.

Personal Care Attendant- Complex Care

In addition to meeting the above criteria for Personal Care Attendant, complex care may be medically necessary when the below criteria is met**.**

The Plan may authorize the coverage of PCA Complex Care services when **ALL** of the following criteria are met:

1. Evaluation for PCA services demonstrates the member requires physical assistance with **One** of the following:
    a. Digital rectal stimulation (DRS) related to bowl regimen; **or**
    b. Feedings via enteral tube (G & J) (exclude medication administration)
2. A completed PCA evaluation or PCP summary form showing the clinical need for assistance with DRS or feedings via enteral tube and whether these tasks are appropriate for a PCA provider to perform

Note: PCA complex care tasks will not be approved when they are considered a skilled service under the following circumstance: Member has an enteral tube (G & J) and there is an aspiration risk[8]

Limitations

The Plan does not cover PCA services when:

1. A Member's PCA is a relative (cannot be a legally responsible relative) (e.g. spouse of the Member or parent of a minor Member)
2. A Member's PCA cannot be the Member's surrogate
3. Member is a resident or at an inpatient status at a hospital, nursing facility, or intermediate care facility for people with intellectual disabilities
4. Services are for babysitting, recreation, advocacy, guiding/coaching, or safety
5. Services are provided to a Member during the time a member is participating in a community funded program, including, but not limited to, day habilitation, adult day health, adult foster care, or group foster care, etc.

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
99509	Home visit for assistance with activities of daily living and personal care
H0043	Supported housing, per diem
S5100	Day care services, adult; per 15 minutes
S5101	Day care services, adult; per half day
S5102	Day care services, adult; per diem
S5140	Foster care, adult; per diem
T1999	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks"
T1019	Personal care services, per 15 minutes
T1019 with modifier TG	Personal Care attendant complex care

The following code(s) do not require prior authorization:

Table 2: CPT/ HCPCS Codes

Code	Description
S5100 with modifier CG	Interim PA, Day care services, adult; per 15 minutes
S5101 with modifier CG	Interim PA, Day care services, adult; per half day
S5102 with modifier CG	Interim PA, Day care services, adult; per diem

References:

1. Commonwealth of Massachusetts Department of Elder Affairs: 651 CMR 3.00: Home Care Program, 2017. Available at mass.gov/regulations/651-CMR-3-home-care-program. Accessed September 10, 2025.
2. Commonwealth of Massachusetts. 130 CMR 404.00: Adult Day Health Services, 2018. mass.gov/regulations/130-CMR-40400-adult-day-health-services. Accessed September 10, 2025.
3. Commonwealth of Massachusetts. 130 CMR 630.000: Home – and Community-Based Services waiver Services, 2025. mass.gov/regulations/130-CMR-63000-home-and-community-based-services-waiver-services. Accessed September 10, 2025.
4. Commonwealth of Massachusetts. 130 CMR 419.000: Day Habilitation Center Services, 2004. mass.gov/regulations/101-CMR-34800-day-habilitation-program-services. Accessed September 2025.
5. Commonwealth of Massachusetts. 130 CMR 450.000 Group Adult Foster Care Group Adult Foster Care and Manual for MassHealth Providers, Chapter 4, Adult Foster Care Providers Regulations, March 2024. Adult Foster Care Manual for MassHealth Providers | Mass.gov. Accessed September 10, 2025.
6. Commonwealth of Massachusetts. 130 CMR 422:00: Personal Care Attendant Services Manual for MassHealth Providers, Chapter 4 Program Regulations, 2026. https://www.mass.gov/doc/personal-care-attendant-services-regulations/download. Accessed July 10, 2026.
7. Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid. Personal Care Attendant Bulletin 17, June 2025. Available at Mass Health Personal Care Attendant Bulletin. Accessed September 10, 2025.
8. Day Habilitation Manual for MassHealth Providers. Commonwealth of Massachusetts MassHealth Provider Manual Series. January 30, 2026. Accessed February 13, 2026. https://www.mass.gov/lists/day-habilitation-manual-for-masshealth-providers
9. Transmittal Letter DH-35: Day Habilitation Updates to Subchapter 6. Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid. January 2026. Accessed February 13, 2026. https://www.mass.gov/doc/dh-35-day-habilitation-manual-updates-to-subchapter-6/download.
10. 1. PERSONAL CARE ATTENDANT PROGRAM OPERATING STANDARDS. mass.gov. May 2026. Accessed July 2026. https://www.mass.gov/doc/pca-operating-standards/download.

Approval And Revision History

July 27, 2021: Reviewed by the Integrated Medical Policy Advisory Committee with an effective date of 10/1/2021.

Subsequent endorsement date(s) and changes made:

- October 20, 2021: Reviewed by IMPAC; HCPCS codes S5125, T1028 and T2041 removed effective 1/1/2022
- April 7, 2022: Template updated
- December 1, 2022: Reviewed by MPAC, renewed without changes
- March 15, 2023: Reviewed by MPAC with an effective date of May 1, 2023; specific services and associated codes identified that can be authorized for up to 1 year.
- September 20, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care and clarified One Care criteria effective January 1, 2024
- October 17, 2024: Reviewed by MPAC, annual review and minor criteria changes made to Day Habilitation criteria to align with Mass Health guidelines, effective December 1, 2024.
- October 15, 2025: Reviewed by MPAC, annual review completed; added criteria and modifier TG to code T1019 for PCA complex care services based on Mass Health implementation of PCA Complex Care service, effective January 1, 2026
- November 12, 2025: 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
- December 8, 2025: Reviewed by UM Committee to remove the following services and moved them to Non- Covered Home and Community Based services- Flexible Benefits Tufts Health One Care MNG: chore (S5120 and S5121), companion (S5135 and S5136), grocery and shopping, home delivered meals (S5170 and S9977)), home health aide (G0156), homemaking (S5130 and S5131), skills training (H2014), laundry (S5175), and supportive home care aide as well as S5165 effective January 1, 2026
- December 17, 2025: Reviewed by MPAC to remove the following services and moved them to Non- Covered Home and Community Based services- Flexible Benefits Tufts Health One Care MNG: chore (S5120 and S5121), companion (S5135 and S5136), grocery and shopping, home delivered meals (S5170 and S9977), home health aide (G0156), homemaking (S5130 and S5131), skills training (H2014), laundry (S5175), personal cares services (T1019) and supportive home care aide as well as S5165 effective January 1, 2026
- February 18, 2026: Reviewed by MPAC, added note about Day Habilitation now falling interim PA per Subchapter 6 updates, included S5100-CG, S5101- CG, S5102-CG effective April 1, 2026
- June 17, 2026: Code T1019 added to MNG to require Prior Authorization effective October 1, 2026

- July 15, 2026: Reviewed by MPAC, criteria for Personal Care Attendant Meal Preparation updated to outline that PCA food prep is capped at seven hours per week unless PA demonstrating medical necessity is submitted. Meal prep by a personal care attendant under seven hours will not require PA; 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 log.