Medical Necessity Guidelines:

# Non-Covered Home and Community Based Services- Flexible Benefits for Tufts Health One Care

*Effective: August 1, 2026*

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|---|---|
| **Prior Authorization Required**<br>If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below | Yes ☒ No ☐ |
| **Notification Required**<br>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 Plan – 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

The Plan may cover medically necessary Flexible Benefits for a Member on Tufts Health One Care Dual Eligible Special Needs Plan. These are items or services not otherwise covered by Medicare or MassHealth. These items or services are unique to each member and their individual needs and situations to fill a gap when no other resource is available. **Prior authorization may be required**, and documentation must be provided in the member's Individualized Care Plan. Some of the services now covered below under the Dual Eligible Special Needs Plan Flexible Benefits Plan were previously covered by the Plan under the Long Term Supports and Services, Respite, and Home Accessibility Adaptations Medical Necessity Guidelines under the guidance of the 1115 pilot program. Some services remain under the Long-Term Support and Services Medical Necessity Guidelines, see the provider resource center for more information.

| Service | Benefit |
|---|---|
| Environment Accessibility Adaptions | Flexible Benefit- see below |
| Home Accessibility Adaptations | Flexible Benefit and specific criteria- see below |
| Respite | Flexible Benefit and specific criteria- see below |
| Assistive/Adaptive Technology | Flexible Benefit- see below |
| Chore | Flexible Benefit and specific criteria- see below |

| | |
|---|---|
| Grocery Shopping | Flexible Benefit and specific criteria- see below |
| Home Delivered Meals | Flexible Benefit and specific criteria- see below |
| Laundry | Flexible Benefit and specific criteria- see below |
| Adult Companion | Flexible Benefit and specific criteria- see below |
| Home Health Aide | Flexible Benefit and specific criteria- see below |
| Homemaker | Flexible Benefit and specific criteria- see below |
| Supportive Home Care Aide | Flexible Benefit and specific criteria- see below |
| Independent Living Skills Training | Flexible Benefit and specific criteria- see below |
| Peer Supports | Flexible Benefit- see below |
| Personal Assistance Services: Agent Model | Flexible Benefit and specific criteria- see below |
| Transportation (Non-medical/ Social) | Flexible Benefit- see below |
| Adult Foster Care | See LTSS Medical Necessity Guidelines |
| Group Adult Foster Care | See LTSS Medical Necessity Guidelines |
| Personal Care Services | See LTSS Medical Necessity Guidelines |
| Personal Care Attendant | See LTSS Medical Necessity Guidelines |
| Personal Care Attendant: Complex Care | See LTSS Medical Necessity Guidelines |
| Adult Day Health | See LTSS Medical Necessity Guidelines |
| Day Habilitation | See LTSS Medical Necessity Guidelines |
| Additional 1115 waiver services | Flexible Benefit specific criteria- see below |

**This is not a full list of covered Flexible Benefit Services, additional services may be covered under the all Flexible Benefits criteria below.**

Definitions:

- **Flexible Benefits**: are items or services not covered by Medicare or MassHealth (Medicaid) that improve health and are documented in the Individualized Care Plan (ICP).
- **Covered services:** The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services that our plan covers.
- **Individualized Care Plan (ICP or Care Plan):** A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.
- **Medically necessary:** This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

  In accordance with Medicaid law and regulation, and per MassHealth, services are medically necessary if:
  - They could be reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger your life, cause you suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and
  - There is no other medical service or place of service that is available, works as well, and is suitable for you that is less expensive.
- **SMART goal:** a framework for setting objective Smart, Measurable, Achievable, Relevant, and Time specific goals

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. When CMS and MassHealth do not provide guidance, the Plan internally developed medical necessity guidelines are used. CMS and MassHealth do not cover these services, however the Plan will use previously established MassHealth criteria for these services so a Member may continue with care they previously received. The use of this criteria in the utilization management process will ensure access to evidence based clinically appropriate care. See References section below for all evidence accessed in the development of these criteria.

## Clinical Guideline Coverage Criteria

### All Flexible Benefits

The Plan may cover Flexible Benefits when all of the following criteria are met:

1. The requested Flexible Benefit is considered medically necessary and has clinical rationale documented to support a Member's need; **and**
2. The requested Flexible Benefit is documented as a SMART goal within the Members' Care Plan; **and**
3. The requested Flexible Benefit meets one of the following:
    a. promotes independence or recovery
    b. positively impacts outcomes (i.e. health, safety, stability, or functional ability)
    c. addresses access or other barrier(s) that will lead to a Member achieving goals in their Care Plan; **and**
4. The Care Plan provides the expected outcome of the requested Flexible Benefit; **and**
5. Documentation shows that all Covered Benefits, as well as less costly alternatives, have been tried and failed or are not medically appropriate for the Member's needs

## Select Service Specific Criteria

In addition to the criteria above, the Plan had established clinical criteria in place for services that were previously covered under the 1115 waiver pilot, these services were claims based and criteria below will apply also apply to those specific services. If there is not individual criteria below, please submit with just the All Flexible Benefit criteria above.

### ASSISTIVE/ ADAPTIVE TECHNOLOGY (AT)

Assistive/ adaptive technology is any type of device, system, or equipment that expands the capabilities of people with disabilities

The Plan may authorize the coverage of an assistive/ adaptive technology when **ALL** of the following criteria are met:

1. The assistive/ adaptive technology is excepted to reduce an increased in home based services, including PCA services, or it will prevent hospitalization, emergency department visits, or Skilled Nursing Facility placements

### CHORE (LIGHT & HEAVY)

Chore services (light and heavy) provide assistance to members to maintain their home in a clean, sanitary, and safe manner. Heavy chore services include but are not limited to assistance with minor home repairs, general maintenance, and household chores such as washing floors, windows, walls, taking down loose rugs and tiles and moving heavy items of furniture to provide safe access and egress. Light chore services include assistance with vacuuming, dusting, dry mopping, cleaning bathrooms and kitchens. Members can be authorized for light chore or heavy chore services for up to 1 year.

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

1. The Member must have a physical, medical, mental, or cognitive cognition that impairs their ability to complete associated task(s) allowing them to maintain their home or prevent environmental defects that are hazardous to their health or safety; **and**
2. The Member does not have an informal support or someone residing in the immediate household who can provide assistance with the associated task(s); **and**
3. The task(s) are not considered the responsibility of member's property management company, housing authority, or landlord pursuant to a lease agreement; **and**
4. Heavy chore services are utilized on a one-time or short-term basis; **and**
5. Heavy chore and light chore services are appropriate, non-duplicative, and part of the Member's individual care plan; **and**
6. Chore services are expected to prevent hospitalization, emergency department visits, or Skilled Nursing Facility placements

### COMPANION SERVICES (COMP)

Companion services provide non-medical care, supervision, and socialization for a Member and are provided in accordance with a therapeutic goal in the service plan. COMP services may assist or supervise the Member as an escort to appointments for Members who do not require any hands-on care or assistance. Adult companion services are covered where the adult companion enables the participant to function with greater independence within the participant's home or community. The Member can be authorized for companion (COMP) services for up to 6 months.

The Plan may authorize the coverage of COMP services when **Both** of the following criteria are met:

1. The Member must have a physical, medical, mental, or cognitive condition that requires supervision or support; **and**
2. COMP services must be appropriate, non-duplicative and part of the Member's individual care plan that outlines

what COMP services will be provided.

**Limitations**

The Plan does not cover COMP services when:

1. COMP services are purely recreational or diversionary in nature.

## GROCERY & SHOPPING (GRO)

GRO services provide assistance to members to order groceries, shop for groceries, deliver groceries and assist with the storage of groceries as needed. Members are responsible for paying for any groceries that are ordered or purchased and may not be able to utilize SNAP benefits. Members can be authorized for GRO services for up to 6 months.

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

1. The Member must be either homebound or infrequently leaves the home due to a physical or mental condition; **and**
2. The Member does not have an informal support or someone residing in the immediate household who can provide assistance with ordering or shopping for groceries; **and**
3. The Member is unable to carry or lift items independently or with assistance; **and**
4. The Member is unable to utilize any other grocery delivery service offered by local supermarkets/applications; **and**
5. The Member does not receive any other service in which assistance with ordering or shopping for groceries can be provided; **and**
6. Grocery & Shopping (GRO) services must be appropriate, non-duplicative, and part of the Member's individual care plan; **and**
7. Grocery shopping is except to prevent hospitalization, emergency department visits, or Skilled Nursing Facility placement

## HOME or ENVIRONMENT ACCESSIBLE ADAPTIONS

Home or Environment 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.

The Plan considered Home or Environment 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 Home or Environment Accessibility Adaptations 2 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 or Environment 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 or environment 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; **and**
8. The home or environment modification are excepted to reduce or prevents an increase in home-based services including PCA services, or they are expected to prevent hospitalization, emergency department visits, or Skilled nursing Facility placements

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

**HOME DELIVERED MEALS (HDMs)**

HDMs provide members with well balanced meals (hot, cold, or frozen) that meet federal and state guidelines. Members can be authorized for home delivered meals for up to 1 year.

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

1. The Member must have a physical, medical, mental, or cognitive condition that results in their inability to prepare and/or shop for nutritionally adequate meals; **and**
2. The Member does not have access to or has inadequate kitchen facilities; **and**
3. The Member does not have an informal support or someone residing in the immediate household who can provide assistance with meal preparation; **and**
4. The Member has great difficulty performing Instrumental Activity of Daily Living$_6$ with meal prep and shopping; **and**
5. The Member cannot attend a congregate meal site due to being homebound or infrequently leaving the home or the Member is ineligible for receiving meals through a congregate meal site; **and**
6. The Member does not receive any other service in which they can assistance with meal preparation and/or shopping; **and**
7. Home Delivered Meals (HDM) must be appropriate, non-duplicative, and part of the Member's individual care plan; **and**
8. Home Delivered Meals (HDM) should not exceed 1 meal per day unless the Member has an extraordinary circumstance that would result in food insecurity or health issues which has been identified and documented by the Care Manager or LTSS Coordinator; **and**
9. The type of meals required (breakfast, lunch, dinner) must be specified in the Member's functional assessment completed by the LTSS Coordinator; **and**
10. Meals are excepted to prevent hospitalization, emergency department visits, or Skilled Nursing Facility placement

**HOME HEALTH AIDE (HHA)**

HHA services are provided under the supervision of registered nurse or licensed therapist and provide higher acuity members with hands on assistance with ADLs. HHA services may also include assistance with simple dressing changes as ordered by a provider, medication assistance that typically would be self-administered and does not require skill of a nurse, routine care of orthotic/prosthetic devices, and activities that support skilled therapies. HHA services may provide incidental assistance with Instrumental Activities Of Daily Living (IADLs), but the purpose of HHA services cannot solely be for assistance with these tasks. An example of a higher acuity member is a member who requires assistance with respiratory treatments such as a nebulizer or oxygen and/or are less than 50% weight bearing. Members can be authorized for HHA services for up to 90 days

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

1. The Member must have a medically predictable and/or recurring need for nursing services or therapy services; **and**
2. The Member must require hands-on assistance with **at least two** of the following ADLs:
    a. Bathing
    b. Grooming
    c. Dressing
    d. Toileting/continence
    e. Transferring/ambulation
    f. Eating; **and**

3. HHA services must be medically necessary to maintain the Member's health or facilitate the treatment of the Member's injury or illness; **and**
4. The frequency and duration of HHA services must be ordered by the Member's care manager and must be included in the care plan for the Member; **and**
5. HHA services must be appropriate, non-duplicative, and part of member's individual care plan (e.g., home health aide may be providing ADL assistance and additional IADL services, which could potentially be duplicative); **and**
6. The Member's Care Manager must verify the Member's level of acuity through the functorial assessment conducted by the LTSS Coordinator and/or the clinical assessment completed by the servicing provider.

## HOMEMAKING (HM) SERVICES

Homemaking (HM) services provide assistance to members with Instrumental Activities Of Daily Living (IADLs) including grocery shopping (closest to the Member's residence), menu planning, meal preparation, laundry of the eligible member's items only and light housekeeping of the Member's primary living areas of the kitchen, bathroom, living room and the Member's bedroom. Members can be authorized for homemaking services for up to 1 year.

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

1. Member must have a physical, medical, mental, or cognitive condition that prevents them from performing at least one IADL; **and**
2. Member must live alone or with another adult who is unable to perform homemaking duties either due to their own disability or to having dependent children younger than 18; **and**
3. The Member has great difficulty performing Instrumental Activity of Daily Living[6] with household work; **and**
4. Member must be present in the home in order to receive services; **and**
5. Homemaking services must be appropriate, non-duplicative, and part of the Member's care plan; **and**
6. Member does not receive any other service in which assistance can be provided with these tasks; **and**
7. Time allocated should be determined by the amount of tasks/service that is being performed with documentation of specific services and medical necessity; **and**
8. Homemaker services are excepted to prevent hospitalization, emergency department visits, or Skilled Nursing Facility placement

## INDEPENDENT LIVING SKILLS TRAINING (IL-ST)

IL-ST is a service that provides regular or intermittent support designed to develop, maintain and or/maximize the Member's independent functioning in self-care, physical and emotional growth, socialization, communication and vocational skills to achieve the objective of improved health and welfare; and to support the ability of the Member to establish and maintain a residence to live in the community. Members can be authorized for IL-ST services for up to 6 months.

The Plan may authorize the coverage of IL-ST services when the following criteria are met:

1. The Member must have goals identified by the Care Manager or LTSS Coordinator and requires ongoing support related to **at least one** of the following areas:
    a. Consumer/Legal Rights; **or**
    b. Education/Training; **or**
    c. Employment; **or**
    d. Finances/Budgeting; **or**
    e. Healthcare/Nutrition; **or**
    f. Housing; **or**
    g. Self-Care/Daily Living; **or**
    h. Personal/Self-Help; **or**
    i. Social/Recreation.

## LAUNDRY (LAU) SERVICES

Laundry services provide members with assistance in picking-up laundry, washing, drying, folding and delivery of personal laundry items. Members can be authorized for laundry services for up to 6 months. Laundry services are typically provided once per week and includes one bag for items under 20 pounds. Members with items that are than 20 pounds may require multiple bags and and/or a greater frequency of services. Documentation of specific need and medical necessity is required and must be indicated in the Member's functional assessment completed by the LTSS Coordinator. Members can be authorized for laundry services for up to 1 year.

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

1. The Member must have a physical, medical mental, or cognitive condition that prevents them from being able to perform laundry tasks at home at local facilities; **and**
2. The Member does not have access to an operable washer and dryer in their home or building; **and**
3. The Member is unable to travel to a laundromat to perform laundry tasks; **and**
4. The Member has great difficulty performing Instrumental Activity of Daily Living[6] with ordinary housework; **and**
5. The Member does not receive any other service in which assistance can be provided with laundry tasks; **and**
6. The Member does not have an informal support or someone who resides in the immediate household who can provide assistance with laundry tasks; **and**
7. Laundry services must be appropriate, non-duplicative, and part of the Member's individual care plan; **and**
8. Laundry services are excepted to prevent hospitalization, emergency department visits, or Skilled Nursing Facility placement

## PERSONAL ASSISTANCE SERVICES: AGENT MODEL

Personal Assistance Services: Agent Model services provide members with hands-on assistance, prompting or cueing, and supervision to assist lower acuity members with their ADLs, medication reminders, and other tasks such as housekeeping and meal preparation when specifically outlined in care plan. Personal Assistance Services: Agent Model services may provide incidental assistance with Instrumental Activities Of Daily Living (IADLs), but the purpose of Personal Assistance Services: Agent Model services cannot solely be for assistance with these tasks. Members can be authorized for Personal Assistance Services: Agent Model services for up to 6 months

The Plan may authorize the coverage of Personal Assistance Services: Agent Model services when ALL of the following criteria are met:

1. The Member must require prompting, cueing, supervision, or physical assistance with at least one of the following ADLs:
    a. Bathing; or
    b. Grooming; or
    c. Dressing; or
    d. Toileting/Continence; or
    e. Transferring/Ambulation; or
    f. Eating; **and**
2. Personal Assistance Services: Agent Model services must be appropriate, non-duplicative, and part of member's care individual plan; **and**
3. The Member's Care Manager must verify the Member's level of acuity through functorial assessment conducted by the LTSS Coordinator and/or the clinical assessment completed by the servicing provider

## RESPITE

The Plan may cover Respite Care for Tufts Health One Care Members when ALL of the following criteria are met:

1. The Member must have a physical, medical, mental, or cognitive cognition that impairs their ability to take care of themselves and they rely on a non-paid caregiver to assist them with activities related to independent living; **and**
2. The Member is requesting respite care to provide temporary relief to non-paid caregivers; **and**
3. The Member does not have any other assistance with activities related to independent living available to them; **and**
4. The Member is not requesting respite care for the purpose of compensating relief or substitute staff for a paid Respite Care for Tufts Health One Care 2 service provider; **and**
5. The Member will receive the respite services from a qualified individual or organization that meets the requirements of 130 CMR 630.000, provides waiver services to participants, and has signed a provider agreement with the MassHealth agency. The respite provider must be in accordance with all standards, requirements, policies, and procedures established by Massachusetts Rehabilitation Commission (MRC) for the provision of such services to participants of an HCBS waiver, and be
    a. licensed as a hospital
    b. certified as an assisted living residence
    c. licensed as a nursing facility
    d. licensed as a respite care facility
    e. licensed as a rest home
    f. enrolled in MassHealth as a participating adult foster care provider
    g. able to meet site-based respite requirements established by the Massachusetts Department of

**Limitations**

1. Respite care will be covered for up to 360 hours per calendar year

**SUPPORTIVE HOME CARE AIDE (SHCA)**

SHCA is a Home Health Aide (HHA) with specialized training related to diagnosis. Services are provided to members with Alzheimer's/dementia related disease or emotional and/or behavioral health problems to assist with their ADLs and IADLs. SHCA services can also provide emotional support, socialization, and escort services. Members can be authorized for SHCA services for up to 1 year.

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

1. The Member must have a medically predictable recurring need for nursing services or therapy services; **and**
2. Members must have a diagnosis of Alzheimer's/dementia related disease or documented emotional and/or behavioral health problem; **and**
3. The frequency and duration of Supportive Home Care Aide (SHCA) services must be ordered by the care manager and must be included in the care plan for the Member; **and**
4. Supportive Home Care Aide (SHCA) services must be medically necessary to maintain the Member's health or to facilitate the treatment of the Member's injury or illness; **and**

Supportive Home Care Aide (SHCA) services must be appropriate, non-duplicative and part of the Member's individual care plan.

**OVER-THE-COUNTER SERVICES, DENTAL IMPLANTS, AND YMCA MEMBERSHIPS**

1. For each of these services prior authorization is not required, there are not specific clinical criteria. Members may be eligible for these if it is documented in their care plan that the services may help achieve care plan goals.

## Limitations

The Plan will not cover

1. An item/service as a Flexible Benefit if it is covered by Medicare, MassHealth, or is a community benefit
2. The Flexible Benefit if a less costly alternative service is available
3. The Flexible Benefit is not cash, gift cards, or entertainment
4. The Flexible Benefit is not outgoing rent, mortgage, or utility payments
5. The Flexible Benefit is not alcohol, tobacco products, or marijuana
6. The Flexible Benefit if it duplicative of other services in the Members care plan

**Reference the member handbook for a full list of noncovered services**

## Codes

The following code(s) may require prior authorization, please discuss with your care manager:

**Table 1: CPT/HCPCS Codes**

| Code | Description |
|---|---|
| G0156 | Services of home health/hospice aide in home health or hospice settings, each 15 minutes |
| H0045 | Respite care services, not in the home, per diem |
| H2014 | Skills training and development, per 15 minutes |
| T1005 | Respite care services, up to 15 minutes |
| S5120 | Chore services; per 15 minutes |
| S5121 | Chore services; per diem |
| S5130 | Homemaker service, NOS; per 15 minutes |
| S5131 | Homemaker service, NOS; per diem |
| S5135 | Companion care, adult (e.g., IADL/ADL); per 15 minutes |
| S5136 | Companion care, adult (e.g., IADL/ADL); per diem |

| Code | Description |
|---|---|
| S5150 | Unskilled respite care, not hospice; per 15 minutes |
| S5151 | Unskilled respite care, not hospice; per diem |
| S5165 | Home modifications; per service |
| S5170 | Home delivered meals, including preparation; per meal |
| S5175 | Laundry service, external, professional; per order |
| S9977 | Meals, per diem, not otherwise specified |
| T1019 | Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) |

**References:**


1. 130 CMR 630.000: Home – and Community-Based Services waiver Services, 2022. Accessed on October 18, 2024. https://www.mass.gov/doc/home-and-community-based-services-waivers-regulations/download
2. Commonwealth of Massachusetts. 130 CMR 403.00: MassHealth Home Health Agency Bulletin 54, June 2019. mass.gov/files/documents/2019/06/17/pb-hha-54.pdf.
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 April 16, 2026
4. 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 April 16, 2026.
5. Minimum data set - home care (MDS-HC)©. July 21, 1999. Accessed April 16, 2026. https://www.mass.gov/doc/minimum-data-set-home-care-mds-hc-version-20-0/download.


## Approval And Revision History

December 8, 2025: Reviewed by the Joint Medical Policy and Health Care Services Utilization Management Committee (UM Committee), effective January 1, 2026

Subsequent endorsement dates and changes made:

- December 17, 2025: Reviewed by the Medical Policy Approval Committee (MPAC), 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.