Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Therapeutic Mentoring (TM) Services For Tufts Health Together

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

Therapeutic Mentoring (TM) Services are provided to youth (under the age of 21) in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), and other community settings such as a school, childcare centers, respite settings, and other culturally and linguistically appropriate community settings. Therapeutic Mentoring offers structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social, and communication needs.

Therapeutic Mentoring services include supporting, coaching, and training the youth in age- appropriate behaviors, interpersonal communication, functional skill-building, problem-solving and conflict resolution, and relating appropriately to other youth, as well as adults, in recreational and social activities pursuant to a behavioral health treatment plan developed by an outpatient, or In- Home Therapy (IHT) provider in concert with the family, and youth whenever possible, or Individual Care Plan (ICP) for youth in ICC. These services help to ensure the youth's success in navigating various social contexts, learning new skills and making functional progress, while the therapeutic mentor offers supervision of these interactions and engages the youth in discussions about strategies for effective handling of peer interactions.

Therapeutic Mentoring services must be necessary to achieve a goal(s) established in an existing behavioral health treatment plan for outpatient, In-Home Therapy, or in an ICP for youth in ICC, and progress toward meeting the identified goal(s) must be documented and reported regularly to the youth's current treater(s). Services are designed to support age-appropriate

social functioning or ameliorate deficits in the youth's age-appropriate social functioning.

Clinical Guideline Coverage Criteria

Admission Criteria

The Plan considers therapeutic mentoring services as reasonable and medically when ALL of the following criteria are met:

1. A comprehensive behavioral health assessment inclusive of the MA Child and Adolescent Needs and Strengths (CANS) indicates that the youth's clinical condition warrants this service in order to support age-appropriate social functioning or ameliorate deficits in the youth's age- appropriate social functioning. If the Member has MassHealth as a secondary insurance and is being referred to services by a provider who is paid through the Member's primary insurance, the provider must conduct a comprehensive behavioral health assessment. A CANS is not required; and
2. The youth requires education, support, coaching, and guidance in age-appropriate behaviors, interpersonal communication, problem-solving and conflict resolution, and relating appropriately to others to address daily living, social, and communication needs and to support the youth in a home, foster home, or community setting, or, the youth may be at risk for out-of- home placement as a result of the youth's mental health condition, or, requires support in transitioning back to the home, foster home, or community from a congregate care setting; and
3. Outpatient services alone are not sufficient to meet the youth's needs for coaching, support, and education; and
4. Required consent is obtained; and
5. The youth is currently engaged in outpatient services, In-Home Therapy or ICC and the provider or ICC CPT, determine that Therapeutic Mentoring Services can facilitate the attainment of a goal or objective identified in the treatment plan or ICP that pertains to the development of communication skills, social skills and peer relationships.

Continuation Criteria

The Plan considers continuation of therapeutic mentoring services as reasonable and medically necessary when ALL of the following criteria are met:

1. The youth's clinical condition continues to warrant Therapeutic Mentoring Services in order to continue progress toward treatment plan goals; and
2. The youth's treatment does not require a more-intensive level of care; and
3. No less-intensive level of care would be appropriate; and
4. Care is rendered in a clinically appropriate manner and focused on the youth's behavioral and functional outcomes as described in the treatment plan/ICP; and
5. Progress in relation to specific behavior, symptoms, or impairments is evident and can be described in objective terms, but goals have not yet been achieved, or adjustments in the treatment plan/ICP to address lack of progress are evident; and
6. The youth is actively participating in the plan of care to the extent possible consistent with their condition; and
7. Where applicable, the parent/guardian/caregiver and/or natural supports are actively involved as required by the treatment plan/ICP; and
8. For those youth discharging from Outpatient, In-Home Therapy, or Intensive Care Coordination, services may continue until the next CANS re-evaluation date.

Discharge Criteria

The Plan considers discharge from therapeutic mentoring services appropriate for **ANY** of the following:

1. The youth no longer meets admission criteria for this level of care or meets criteria for a less- or more-intensive level of care.
2. The treatment plan/ICP goals and objectives have been substantially met, and continued services are not necessary to prevent worsening of the youth's behavioral health condition.
3. 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.
4. Required consent for treatment is withdrawn.
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 it required to maintain the current level of functioning.
6. 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.

**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 and Exclusions:

The Plan considers therapeutic mentoring services not medically necessary for **ANY** of the following criteria:

1. The youth displays a pattern of behavior that may pose an imminent risk to harm self or others, or sufficient impairment exists that requires a more-intensive service beyond community-based intervention.
2. The youth has medical conditions or impairments that would prevent beneficial utilization of services.
3. Therapeutic Mentoring services are not needed to achieve an identified treatment goal.
4. The youth's primary need is only for observation or for management during sport/physical activity, school, after-school activities, or recreation, or for parental respite.
5. The service needs identified in the treatment plan/ICP are being fully met by similar services.
6. The youth is placed in a residential treatment setting with no plans for return to the home setting.

Codes

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

Table 1: CPT/HCPCS Codes

Code	Description
T1027	Family training and counseling for child development, per 15 minutes

References:

1. Commonwealth of Massachusetts, Executive Office of Health and Human Services, MassHealth Medical Necessity Criteria for Therapeutic Mentoring Services effective September 15, 2024 .pdf .
2. Massachusetts Behavioral Health Partnership Children's Behavioral Health Initiative (CBHI) Overview, accessed at https://www.masspartnership.com/mbhp/en/home/services/cbhi#item_1 on 10/4/2024.

Approval And Revision History

October 17, 2024: Reviewed by Medical Policy Approval Committee (MPAC). New Medical Necessity Guideline (MNG), effective September 15, 2024.

Subsequent endorsement date(s) and changes made:

- 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.