Medical Necessity Guidelines: Child Care Services for Members enrolled in Tufts Health Plan's Healthy Birthday Program

Effective: June 17, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:
COMMERCIAL Products
☒Tufts Health Plan Commercial products; Fax: 617.972.9409
☒Tufts Health Freedom Plan products; Fax: 617.972.9409
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☐Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☐Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☐Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☐Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) **–** Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

This guideline is used to determine coverage of childcare services for participants enrolled in Tufts Health Plan's Healthy Birthday Program.

CLINICAL COVERAGE CRITERIA

Tufts Health Plan may authorize childcare services for Members meeting **all** of the following:
- Pregnant Member actively participating in Tufts Health Plan's Healthy Birthday program
- Current order from the obstetrical provider for **complete** bedrest at home (being up for meals and bathroom privileges only) because of a pregnancy-related complication, **AND**
  - All family and community resources to provide child care have been exhausted
  - The Member would otherwise be unable to follow the physician's plan of care

Note: When child care services are authorized the following apply:
- The child care benefit will be authorized for up to one month with requests for extensions reviewed by Tufts Health Plan case management on a case-by-case basis
- The Member will be responsible for obtaining the child care provider of their choice
- The maximum allowance for the child care provider will be up to $250.00 per week
- Tufts Health Plan may randomly audit any and all child care reimbursement claims/receipts

LIMITATIONS

- Tufts Health Plan will not continue reimbursement for authorized childcare services when:
  - The Member is no longer covered by Tufts Health Plan
  - The Member is hospitalized for greater than 48 hours
  - The Member is no longer on complete bed rest
  - The Member reaches 37 weeks gestation
  - The Member has delivered

CODES

None

REFERENCES

None

APPROVAL HISTORY

September 1999: Reviewed by the Clinical Coverage Criteria Committee

Subsequent endorsement date(s) and changes made:

- October 2000: Renewed
- October 2001: Renewed
- October 2002: Renewed, no changes.
- October 30, 2003: Reviewed and renewed, updated to new format.
- November 23, 2004: Reviewed and renewed.
- November 4, 2005: Reviewed and renewed, EOB letter changed.
- November 17, 2006: Reviewed and renewed without changes.
- November 28, 2007: Reviewed and renewed without changes.
- December 17, 2008: Reviewed and renewed without changes.
- December 16, 2009: Reviewed and no changes made.
- December 2010: Reviewed by Medical Specialty Policy Advisory Committee (MSPAC). No changes.
- December 14, 2011: Reviewed by MSPAC and Integrated Medical Policy Advisory Committee (IMPAC) no changes.
- November 28, 2012: Reviewed by IMPAC, renewed without changes.
- October 9, 2013: Reviewed by IMPAC, renewed without changes.
- October 8, 2014: Reviewed by IMPAC, renewed without changes.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- November 16, 2015: Reviewed by IMPAC, renewed without changes.
- November 9, 2016: Reviewed by IMPAC, renewed without changes.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017.
- October 11, 2017: Reviewed by IMPAC, wording and format edits. Link added to the Healthy Birthday Program general information page.
- July 25, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- July 17, 2019: Reviewed by IMPAC, renewed with no changes
- June 17, 2020: Reviewed by IMPAC, renewed with no changes
- June 24, 2020: Fax number for Unify updated

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.

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.