Medical Necessity Guidelines:
Personal Assistance Services & Supports (PASS)

Effective: October 21, 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

OVERVIEW

Personal assistance services & supports (PASS) is designed to enable children and youth with special health care needs to grow, develop and live as independently as possible in their homes and community. It is a comprehensive integrated program that includes intermittent, limited, or extensive one-to-one personal assistance services needed to support, improve or maintain functioning in age appropriate natural settings. It is available to children diagnosed with certain physical, developmental, behavioral or emotional conditions living at home. PASS is designed to assist children and youth with attaining goals and identifying objectives within three areas:

- Activities of daily living
- Making self-preserving decisions
- Participating in social roles and social settings

PASS is not for children exhibiting marked impairment involving self-control, severe disturbances in thinking, perception, mood or learning disabilities. All treatment objectives are individually determined and associated with specified activities and interventions with a schedule for participation, and measurable outcomes. PASS is not intended to replace or supplement school based services, behavioral health treatment, certified nursing services, or respite.

Treatment intensity is based on the individual needs of a child. A qualified PASS agency is responsible, along with a qualified health professional, for all assessment and service plan development.

CLINICAL COVERAGE CRITERIA

Admission Coverage Criteria

All of the following criteria must be met for admission:

1. Member is less than 21 years of age.
2. A less intensive or restrictive level of care would not be appropriate to meet the member's needs nor would a more intensive level of care

3. The member has a formal DSM or corresponding ICD-CM psychiatric, medical, or developmental diagnosis made by a licensed health care professional within the last 2 years. The professional must have a competence in child psychology, child psychiatry, or child development.
4. The member demonstrates symptoms and behaviors consistent with a current DSM/ICD diagnosis that requires therapeutic intervention for functional impairments that significantly interferes with or limits the member's role or functioning in family, school, or community activities.
5. The member lives with parent/guardian in the home; and the parent/guardians are capable and willing to participate, accept the responsibilities of, and cooperate with the program requirements outlined in the PASS Service Plan.
6. The member has the capacity to maintain or improve functioning in physical, behavioral, or cognitive development; communication; socialization; and community participation with PASS.
7. PASS can be provided in the home or community without compromising the member's or worker's health and safety.

Continuation Coverage Criteria

All of the following criteria must be met:

1. Member continues to meet admission criteria.
2. Severity of condition(s) and resulting impairment continue to require PASS service plan to maintain and/or improve level of adaptive and functional skills. Clinical information must show that the member is disabled with evidence of functional impairment(s).
3. The member's progress in relation to goals is clearly evident, measurable, and described in observable terms.
4. Parent/guardian is participating, accepting the responsibilities of, and cooperating with the program requirements as indicated by PASS Service Plan.
5. Coordination of care and real time discharge planning are continuing.

Discharge Coverage Criteria

The following criteria will result in terminated or suspended Service Plan:

1. Member meets criteria for a less/more intensive level of care.
2. Member has demonstrated sufficient improvement and/or the Service Plan goals and objectives have been successfully met; and continued services are not necessary to prevent the decline of member's functioning.
3. Member or parent/guardian is not successfully following program rules or regulations and is no longer capable or willing to participate to the extent required as agreed upon and has withdrawn consent for treatment. PASS provider must be able to display multiple documented attempts to work with the member/parent/guardian.
4. Member's home environment poses a safety risk to the PASS worker or agency staff.
5. The member no longer needs assistance beyond the family/guardian to perform age-appropriate cognitive, physical and social activities.
6. Member no longer resides in the community with parent/guardian.
7. Member turns 21 years of age.

LIMITATIONS

Tufts Health Plan will not cover PASS for the following reasons:

1. PASS will not replace Private Duty Nursing or Certified Nursing Assistants services. If nursing or CNA services are needed along with PASS, these services will not be provided concurrently.
2. Member will not use PASS for Respite or childcare.
3. PASS will not be used in isolation when other support services are indicated. PASS is expected, when applicable, to be used as a complement to other services (family or individual psychotherapy, medical treatments, school services and Early Intervention.
4. PASS will not be used as a substitute for mental health services provided by licensed professional clinicians.

CODES

The following HCPCS code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Code	Description
H2014	Skills training and development, per 15 minutes

HCPCS Code	Description
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)
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter
T1027	Family Training and counseling for child development, per 15 minutes
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
H2016	Comprehensive community support services, per diem
H2021	Community-based wrap-around services, per 15 minutes
H2022	Community-based wrap-around services, per diem
H2037	Developmental delay prevention activities, dependent child of client, per 15 minutes
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes
G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	Community psychiatric supportive treatment program, per diem
H0039	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive community treatment program, per diem
H2015	Comprehensive community support services, per 15 minutes
H2016	Comprehensive community support services, per diem
T1040	Medicaid certified community behavioral health clinic services, per diem
T1041	Medicaid certified community behavioral health clinic services, per month

REFERENCES

1. State of Rhode Island, EOHHS, Model Contract for Medicaid Managed Care Services, winter 2017, Attachment O: Mental Health, Substance Use and Developmental Disabilities Services for Children.
2. State of Rhode Island, EOHHS, Practice Standards, Providers of Personal Assistance Services and Supports, January 1, 2016

APPROVAL HISTORY

January 11, 2017: Reviewed by the Integrated Medical Policy Advisory Committee for effective date of August 1, 2017.

Subsequent Endorsement Dates and Changes Made:

- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- September 7, 2017: Administrative, table title updated
- October 10, 2018: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 4, 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.