Medical Necessity Guidelines:
Respite Care for Tufts Health Unify

Effective: October 1, 2023

<table>
<thead>
<tr>
<th>Prior Authorization Required</th>
<th>Yes ☒ No ☐</th>
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<tr>
<td>If REQUIRED, submit supporting clinical documentation pertinent to service request.</td>
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<tr>
<th>Notification Required</th>
<th>Yes ☐ No ☒</th>
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<tr>
<td>IF REQUIRED, concurrent review may apply</td>
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Applies to:

**Commercial Products**

☐ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☐ Tufts Health Plan Commercial products; 617-972-9409

CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

**Public Plans Products**

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); 857-304-6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

**Senior Products**

☐ Harvard Pilgrim Health Care Stride Medicare Advantage; 866-874-0857
☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

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**

Respite Services are services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of unpaid caregivers, as defined by the Commonwealth of Massachusetts Program Regulations for Home- and Community- Based Services, 130 CMR 630.000. Respite services give unpaid Caregivers a temporary reprieve from caregiver responsibilities to allow for a period of rest and relaxation and/or for the opportunity to attend to their own personal needs. Respite services can be provided in the home, as well as other care settings such as skilled nursing facilities (SNFs), assisted living facilities (ALFs), rest homes, licensed respite facilities and hospitals. Respite services are provided for limited periods of time, ranging from a few hours to one or two weeks.

**Clinical Guideline Coverage Criteria**

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

1. The Member must have a physical, medical, 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 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 Developmental Services under 115 CMR 7.00: Standards for All Services and Supports

Limitations

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

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>H0045</td>
<td>Respite care services, not in the home, per diem</td>
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<tr>
<td>T1005</td>
<td>Respite care services, up to 15 minutes</td>
</tr>
<tr>
<td>S5150</td>
<td>Unskilled respite care, not hospice; per 15 minutes</td>
</tr>
<tr>
<td>S5151</td>
<td>Unskilled respite care, not hospice; per diem</td>
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References:

1. 130 CMR 630.000: Home – and Community-Based Services waiver Services, 2022.

Approval And Revision History

June 21, 2023: Reviewed by the Medical Policy Approval Committee (MPAC), new Medical Necessity Guideline for Tufts Health Plan Unify, effective October 1, 2023

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 policy, 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.