Companion Services
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Companion Services		
MNG #: 082	☒ **CCA Senior Care Options (HMO D-SNP) (MA)** ☒ **CCA One Care (Medicare-Medicaid) (MA)**	**Prior Authorization Needed?** ☒ **Yes (always required)** ☐ **Yes (only in certain situations. See this MNG for details)** ☐ **No**
Benefit Type: ☐ **Medicare** ☒ **Medicaid**	**Approval Date:** 9/2/2021;	**Effective Date:** 2/06/2022; 3/13/2025
Last Revised Date: 5/30/2022; 11/14/2024; 3/13/2025	**Next Annual Review Date:** 9/2/2022; 5/30/2023; 11/14/2025	**Retire Date:**

OVERVIEW

Adult Companion Services (COMP) are non-medical care, supervision and socialization services provided to an adult. Companions may assist or supervise with such light household tasks as meal preparation, laundry and shopping. This service is provided in accordance with a therapeutic goal in the service plan. The adult companion enables the member to function with greater independence within the member's home or community.

DEFINITIONS:

Activities of Daily Living (ADLs) - Certain basic tasks required for daily living, including the ability to bathe, dress/undress, eat, toilet, transfer in and out of bed or chair, get around inside the home, and manage incontinence.

Care Team - A team that may consist of your primary care provider (PCP), a nurse practitioner, a registered nurse, a physician assistant, community health worker, or/and a geriatric support services coordinator (GSSC) who are responsible to coordinate all your medical care. "Coordinating" your services includes checking or consulting with you and other plan providers about your care and how it is going.

Care Coordinator - The Care Coordinator is a member's primary Care Partner to navigate the health plan, MassHealth, and Medicare complexities. A Care Coordinator serves as the primary point of contact for the Member and the ICT, participates in the Member's Comprehensive Assessments, provides care planning and the coordination of services, and serves as an internal representative for the Member's needs and preferences within the plan.

CCA Personal Care Plan - Describes the activities and assistance to be performed by the PCS worked, developed by the CCA registered nurse or licensed practical nurse under the supervision of an RN

Clinical Assessment - The comprehensive screening process of documenting a member's need using the Minimum Data Set (MDS) tool to form the basis for prior authorization.

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Comprehensive Assessment - A review of a patient's medical history and current condition. It is used to determine the patient's health and how it might change in the future

Frail Elder Home and Community Based Waiver - A Home- and Community-Based Services (HCBS) waiver designed to make supports available to eligible elders aged 60 and older who meet the level of care for a nursing facility but prefer to remain in the community.

Functional Assessment Tool - A set of questions about a member's health condition and functional needs used in development of member's individualized care plan. Time for each activity are based on guidelines for determining the amount of one:one Activity Time required to perform activities of daily living (ADLs), instrumental activities of daily living (IADLS). These time periods are based on the standard of time it takes a staff person to provide individualized support to a member to perform a specific activity, depending on the level of assistance and behavioral support required by the member. It is recognized that some members may require additional time beyond the time estimates in the guidelines, while others may require less time

Geriatric Support Services Coordinator (GSSC) - A member of a senior care organization's primary care team who is responsible for arranging, coordinating, and authorizing long-term care and social support services for MassHealth members.

Individualized Care Plan (ICP) – A detailed document outlining a member's specific healthcare needs, goals and preferences. It is developed through collaboration between the member and an interdisciplinary care team, and includes a description of how services and care will be integrated and coordinated among providers.

Interdisciplinary Care Team (ICT) - A team consisting of Member, Care Coordinator, Clinical Care Manager (RN and/or BH), PCP, GSSC/LTSC, and other individuals at the Member's discretion. The care team is responsible for effective coordination and care delivery for the Member. The care team works with the Member to develop, implement, and maintain their Individualized Care Plan ("care plan").

Instrumental Activities of Daily Living (IADLs) - Basic tasks, including the ability to prepare meals, do housework, do laundry, go shopping, manage medication, ambulate outside the home, use transportation, manage money, and use the telephone.

Long Term Support Coordinator (LTSC) - Independent community organization experts who work with patients as part of their One Care care team.

Member - A person who is enrolled in the CCA One Care (ICO) or CCA Senior Care Options (SCO) plan.

Minimum Data Set (MDS) - A standardized primary screening and assessment tool that serves as the foundation of the comprehensive assessment. Also referred to as the Clinical Assessment.

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Personal Care - Services provided to a participant, which may include physical assistance, supervision or cuing of participants, for the purpose of assisting the participant to accomplish activities of daily living (ADLs) including, but not limited to, eating, toileting, dressing, bathing, transferring, and ambulation

Time For Task Tool - An assessment based on the standard of time for determining the amount of one:one Activity Time required to perform activities of daily living (ADLs), instrumental activities of daily living (IADLS). These time periods are based on established guidelines for the standard of time it takes a staff person to provide individualized support to a member to perform a specific activity, depending on the level of assistance and behavioral support required by the member. It is recognized that some members may require additional time beyond the time estimates in the guidelines, while others may require less time.

DECISION GUIDELINES

COMP requires prior authorization. Commonwealth Care Alliance (CCA) may cover COMP for non-medical care, supervision and socialization services provided to an adult.

Clinical Coverage Criteria:

In order to be eligible to receive COMP, all of the following criteria must be met:

1. The member must have a physical, cognitive or behavioral-related disability; and
2. The care team must identify the condition or syndrome that underlies the disability, as well as the nature of the functional impairment; and
3. The authorizing clinician must determine that COMP is required for assistance in, or supervision of, such tasks as meal preparation, laundry, shopping, and to escort member to medical appointments in order to increase the independence of the member; and
4. A CCA MDS or GSSC/LTSC Assessment has been completed no more than 6 months before the date of the PA request; and
5. A CCA Time for Task Tool or Functional Assessment has been completed no more than 6 months before the date of the PA request, when member requires assistance or supervision with tasks (as noted in #3 above) based on the aforementioned assessment (#4); and
6. Documentation must support the hours requested; and
7. COMP must be appropriate, non-duplicative, and part of the member's individual care plan that outlines what type of tasks, aligning with the goals, will be provided; and
8. Any other documentation requested by CCA to support the medical necessity review such as, but not limited to, clinical documentation, member's interim/final GAFC plan of care, evaluations or assessments that support the signs and symptoms pertinent to the chronic or post-acute medical, cognitive, or behavioral health condition.

LIMITATIONS/EXCLUSIONS:

1. COMP does not include assistance with personal care, medication administration/reminders.
2. CCA does not pay for COMP provided in a hospital, nursing facility, intermediate care facility for persons with intellectual disabilities, or any other institutional facility setting providing medical, nursing, rehabilitative, oversight or related care.
3. COMP may not be provided in Adult Day Health centers, Day Habilitation centers, or in combination with any other service or setting that includes oversight or supervision.

5. COMP may not be duplicative of other services that provide IADL services unless there are unique member-specific needs requiring consideration, and those other services do not duplicate services the COMP are expected to provide.
6. COMP may not be combined with Group Adult Foster Care or Assisted Living Services (except as medical escort).
7. COMP is not covered where the services are purely recreational or diversionary in nature.
8. The combination of COMP with homemaker, home health aide, personal care, individual support and community habilitation, and supportive home care aide services is limited to no more than 84 hours per week*.
9. SCO members on the Frail Elder Waiver (FEW) may require this service in their care plan to remain eligible for the waiver. This service may be approved as an exception to existing limitations/exclusions in those instances. Consult with the GSSC for additional information.
10. If a member requires constant supervision, Companion would not be the appropriate service. Other services such as Adult Foster Care or Assisted Living should be considered.
11. If the member is able to perform certain tasks but requires supervision when completing these tasks, COMP would be the appropriate service. However, if the member requires help with the task but not the supervision, HM would be the more appropriate service (see MNG #076 Homemaker Services – Agency-Delivered).

* Exceptions may be granted to the limit on a 90-day basis in order to maintain a member's tenure in the community, to provide respite to a caregiver who lives with the participant, to facilitate transitions to a community setting, to ensure that a participant at risk for medical facility admission is able to remain in the community, or to otherwise stabilize a participant's medical condition. Exceptions may also be granted for participants awaiting transition to a residential waiver. **Exceptions to the 84 hour per week limit must be included in the participant's individual plan of care.**

CODING:

When applicable, a list(s) of codes requiring prior authorization is provided. This list is for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment.

HCPCS Code	Description
S5135	Companion care, adult; per 15 minutes

REFERENCES:

1. 101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES 101 CMR 359.00: RATES FOR HOME AND COMMUNITY-BASED SERVICES WAIVERS (7/1/2023). Retrieved from https://www.mass.gov/doc/rates-for-home-and-community-based-services-waivers-effective-july-1-2023-0/download
2. Mass Health 130 CMR 630: DIVISION OF MEDICAL ASSISTANCE HOME- AND COMMUNITY-BASED SERVICES WAIVER SERVICES (5/27/2022). Retrieved from https://www.mass.gov/doc/130-cmr-630-home-and-community-based-services-waiver-services/download
3. Mass Health 130 CMR 630.410 https://www.mass.gov/doc/130-cmr-630-home-and-community-based-services-waiver-services/download
4. Program Instruction for ASAP Executive Directors PI-09-13 (08/21/2009)

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Disclaimer

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses evidence based InterQual© criteria, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists. Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

This Medical Necessity Guideline is not a rigid rule. As with all CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity [supporting literature (full text preferred) should be attached to the request], or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

REVISION LOG:

REVISION DATE	DESCRIPTION
3/13/2025	Template update; revised definition per MH review - removed "Services" from Long Term Support Services Coordinator (LTSC).
12/17/2024	Utilization Management Committee Approval
11/14/2024	Annual review; Added definitions; Added limitation to service hours to 84, with exception; Revised to current template.
5/30/2022	Template changed to include PA requirements and benefit type.

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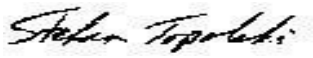
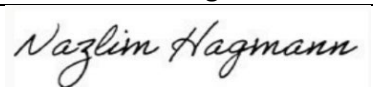
APPROVALS:

Stefan Topolski	**Medical Director**
CCA Clinical Lead	**Title**
	3/13/2025
Signature	**Date**
Nazlim Hagmann	**Chief Medical Officer**
CCA CMO or Designee	**Title**
	3/13/2025
Signature	**Date**