Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: One Care Flexible Benefits		
MNG #: 131	☐ **SCO** ☒ **One Care**	**Prior Authorization Needed?** ☒ **Yes** (always required), for all services except Non-Medical Transportation ☐ **Yes** (only in certain situations. See this MNG for details) ☒ **No**, for Non-Medical Transportation
Clinical: ☒	**Operational:** ☒	**Informational:** ☐
Benefit Type: ☐ **Medicare** ☐ **Medicaid** ☒ **Flexible Benefits**	**Approval Date:** 1/29/2026	**Effective Date:** 1/1/2026
Last Revised Date:	**Next Annual Review Date:** 1/29/2027	**Retire Date:**

OVERVIEW:

This medical necessity guideline outlines the parameters for evaluating and authorizing service exceptions available to One Care members via Flexible Benefits. While the expectation is covered benefits will meet members' needs, there may be extraordinary circumstances that require additional benefits through flexible benefits.

Any service not listed as a covered Medicare or Medicaid benefit in the Member Handbook is considered non-covered. One Care allows for the use of Flexible Benefits to address a member's needs that cannot be met with covered benefits, informal supports, or community resources. Flexible Benefits are defined as "items or services other than – or beyond the amount, duration, and scope – of covered services that may promote independent living or recovery, positively impact outcomes, or address access or other barriers to achieving goals in the [Individualized Care Plan]." Commonwealth Care Alliance (CCA) may offer the following One Care Flexible Benefits (in alphabetical order):

(A) Adult Companion (Medical Escort)
(B) Chore
(C) Home Delivered Meals
(D) Home/ Environmental Accessibility Adaptations
(E) Homemaker
(F) Laundry
(G) Non-Medical Transportation

Note: Non-Medical/Non-Emergent Transportation is a flexible benefit, but functions differently as each member can utilize up to 10 one-way rides per month with no prior authorization needed.

One Care Flexible Benefits are reserved for members who have not been successful utilizing other covered benefits and where the service is imperative for their overall health and wellbeing. These services, while not routinely covered, may be authorized when deemed essential to support a member's wellness, recovery, self-management of chronic conditions, and ability to live independently in the community and cannot be met through other avenues. Exception requests must align with the goals and needs identified in the Individualized Care Plan (ICP) and follow a person-centered planning process.

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While CMS and MassHealth do not provide these home and community-based services, CCA believes they are important to help members maintain their independence in the home. The eligibility criteria and services limits were created using times on the Time for Task Guidelines for the MassHealth PCA Program and 130 CMR 630.000: Home- and Community-based Services Waiver

Services offered under Flexible Benefits are determined on a case-by-case basis based on member circumstances and plan criteria in effect at the time of the request.

Please refer to the CCA Payment Policy on Deeming regarding the use of Flexible Benefits during a deeming period.

Providers are encouraged to work with the member's care team, submit requests with supporting documentation as applicable, and will receive determinations following review. The care team is responsible for working with the member to evaluate the member's individual needs and available support to aid in identifying and coordinating appropriate care.

All other available resources must be exhausted prior to considering Flexible Benefits including, but not limited to covered services, informal supports, and community resources. Prior authorization is required (except for non-medical transportation).

The scope of this Medical Necessity Guideline is limited to One Care members.

DEFINITIONS:

Note: Services are defined in their respective section of this document.

Appropriate Covered Services: Community supports, covered by the One Care Medicaid plan, including adult foster care, group adult foster care and consumer directed Personal Care Attendant.

Covered Services and Items: Treatment and supports that are eligible for reimbursement with the One Care Medicaid and Medicare Plan, as noted in Section 2.7 and Appendix C of the One Care 2026 Contract. These include:

- All services provided under Medicare Part A, Part B, and Part D
- All Medicaid services listed and defined in Appendix C of CCA's One Care contract
- Pharmacy products that are covered by MassHealth, which are not covered under Medicare

These do not include (a) Flexible Benefits or (b) items or services for which payment is prohibited pursuant to 42 U.S.C. § 1396b(i)(16) and 42 U.S.C. § 1396b(i)(17).

Flexible Benefits: Items or services other than – or beyond the amount, duration, and scope of – Covered Services. Flexible Benefits may be provided to promote independent living or recovery, positively impact outcomes, or address access or other barriers to achieving goals in the ICP when those goals cannot be met through covered services, informal supports or community resources..

Individualized Care Plan (ICP): A person-centered plan developed by the Care Team and the member to address the member's goals and needs. The plan of care outlines the scope, frequency, type, amount, and duration, of all Covered Services provided by the Contractor to the Enrollee as described in Section 2.7 of this Contract.

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Home and Community-Based Services (HCBS): Services provided to support members in their homes and communities.

Home Health Aide Services (HHA): Home Health Aide Services are non-skilled personal care services provided under the supervision of a registered nurse or therapist employed or contracted by a certified home health agency. These services are designed to assist members with at least two Activities of Daily Living (ADLs), which include:

a. Bathing
b. Grooming
c. Dressing
d. Toileting/Continence
e. Transferring/Ambulation
f. Eating

Home Health Aide services must:

a. Be medically necessary to support curative, rehabilitative, or preventative aspects of nursing or therapy.
b. Be ordered by a physician or non-physician practitioner and included in the member's plan of care.
c. Be provided in the member's residence and not for general supervision or safety monitoring.
d. Be delivered by aides who have completed a competency evaluation program as specified in federal and state regulations.

Personal Care Attendant (PCA): The PCA Program is a MassHealth-covered benefit that allows eligible members to receive assistance with Activities of Daily Living (ADLs) through a consumer-directed model. Under this program, the member (or their designated representative) is responsible for recruiting, hiring, training, supervising, and, if necessary, terminating their Personal Care Attendant. This model supports member autonomy and enables individuals to manage their own care in alignment with their preferences and needs. PCA services are intended to help members remain safely in their homes and communities and are available only to those who meet MassHealth eligibility criteria, including a demonstrated need for physical assistance with at least two ADLs related to a chronic condition.

DECISION GUIDELINES:

Clinical Coverage Criteria & Limitations/Exclusions:

There are 3 sub-sections in this section:

(1) Required Criteria for Flexible Benefits
(2) Reference Table: Service-specific Benefit Maximum Limit & Authorization Timeframe
(3) Service-specific explanation including definitions, codes, guidelines, eligibility criteria

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(1) Required Criteria for Flexible Benefits

Requests for any One Care Flexible Benefit service must meet each of the following criteria:

1. The member must have a physical, cognitive or behavioral disability; and
2. The care team must identify the condition that underlies the disability as well as how this benefit will support the member;
3. **Imperative for the overall health & well-being of the member:** The service supports the member's ability to remain safely in the community. It is essential to support a member's wellness, recovery, self-management of chronic conditions, and/or ability to live independently in the community.
4. **Needs cannot be met by covered services, formal or informal supports, or grants/community resources:**

    - All other available covered benefits (i.e., Medicare or Medicaid) to meet the member's needs have been explored and deemed insufficient.

    - Neither the individual nor anyone else in the household is capable of performing or financially providing for services, and where no other relative, caregiver, landlord, community/volunteer agency, or third-party payer is capable of or responsible for their provision.

3. **Not duplicative of other services:** The service is not duplicative of existing MassHealth covered services or community resources (including informal supports). When a member may be concurrently receiving two services that are nominally duplicative or overlapping, duplication of tasks is not allowable.

4. **Documented in the care plan:** The member's Individualized Care Plan (ICP) documents the need, alignment with the service requirements, and rationale for the service.

5. **All required service-specific eligibility criteria are met:** Review section (3) and ensure alignment with all service-specific requirements including definitions and guidelines.

6. **Recent documentation clearly demonstrates the alignment of the member's need with the medical necessity criteria for each service:**

    - Documentation must support the services/ hours requested based on the member's need.

    - Documentation shows that all appropriate Covered Benefits, as well as less costly alternatives, have been tried and were unsuccessful or are not medically appropriate for the Member's needs

    - A Minimum Data Set (MDS-HC) or Long-Term Support Coordinator (LTSC) Assessment must be completed no more than 6 months before the date of the PA request.

    - A CCA Time for Task Tool or Functional Assessment must be completed no more than 6 months before the date of the PA request, when member requires assistance or supervision with tasks

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(2) Reference Table: Benefit Maximum Limit & Authorization Timeframe Maximums

An overview reference table is provided below with benefit maximum limits and maximum authorization timeframes. The member must meet all required eligibility criteria for the service.

- Short-term (acute) needs are expected to improve whereas long-term needs are considered the baseline.
- Upon the conclusion of the authorization timeframe, the member will be reassessed if the need continues. CCA's Clinical Assessment (MDS) or LTSC Assessment will be completed no more than 6 months before the date of the PA request. An in-person assessment may be required, and a Time for Task tool must be completed during the last 6 months.

Service	Benefit Maximum Limits *(Must meet eligibility)*	Authorization Timeframe Maximums
Adult Companion (Medical Escort)	• 2 hours per week	• ***Short-term (acute):*** Up to 90 days, based on need • ***Long-term:*** Up to 6 months, based on need
Chore	• 8 hours per calendar year	• Calendar year; should be used one time per year or occasional if benefit limit not surpassed
Home Delivered Meals	***Post-discharge acute episode*** • 1 meal, 7 days/week (14 days) ***Challenges with physically preparing own meal*** • 1 meal, 7 days/week *Note: If a member's need falls into more than one of these categories, the highest level of service for which they meet criteria should be used; Exceptions will not be combined.*	***Post-discharge acute episode*** • Up to 14 days ***Challenges with physically preparing own meal*** • 6 months
Home/Environmental Accessibility Adaptations	• $15,000 Total lifetime limit (Effective 1/1/2026) for one of the four services in the description	• As needed, as long as lifetime limit has not been met

Homemaker	• 2 hours per week	• ***Short-term (acute):*** Up to 90 days, based on need • ***Long-term:*** Up to 6 months, based on need
Laundry	• 1 bag (20lbs or less) per week	• ***Short-term (acute):*** Up to 90 days, based on need • ***Long-term:*** Up to 6 months, based on need
Non-Medical/Non-Emergent Transportation	• 10 one-way trips up to 50 miles per month *(No prior auth needed)*	• Monthly, does not carry over if unused from prior month

(3) Service-specific explanation

The seven One Care Flexible Benefits are discussed in further detail (in alphabetical order) including definitions, codes, guidelines, and eligibility criteria:

(A) ADULT COMPANION (MEDICAL ESCORT)

For general required criteria, see (1) above.
For benefit limits and authorization timeframes, see reference table in (2) above.

Definition
Adult companion is offered for medical escort services and must be provided in accordance with a therapeutic goal in the service plan.

Code(s)
S5125; S5135

Eligibility Criteria
- **All the criteria noted above, section (1) Required Criteria for Flexible Benefits, must be met and documented in the Individualized Care Plan (ICP), along with;**
    1. Member does not qualify for the ASAP volunteer program and is not eligible for PCA.

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1. Adult companion does not include assistance with personal care, medication administration/reminders.
2. CCA does not pay for companion services 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. Adult companion 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.
4. Adult companion may not be duplicative of other services that provide instrumental Activities of Daily Living (IADL) services unless there are unique member-specific needs requiring consideration, and those other services do not duplicate services the companion services are expected to provide.
5. Adult companion may not be combined with Group Adult Foster Care or Assisted Living Services (except as medical escort).
6. Adult companion is not covered where the services are purely recreational or diversionary in nature.

(B) CHORE

For general required criteria, see (1) above.
For benefit limits and authorization timeframes, see reference table in (2) above.

Definition

Chore services are covered only on a one-time or infrequent basis. Services are provided when needed to maintain the home in a clean, sanitary, and safe environment due to, for example, hoarding or infestation. This service includes minor home repairs, maintenance, and heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service. The person-centered planning process assures that chore services meet the member's goals and assessed needs. The process identifies all services and supports and ensures that there is no duplication among them, or with MassHealth state plan services. This service does not provide routine, light housekeeping assistance; it is focused on heavy chores or repairs.

Chore Services are unusual or infrequent household task(s) required to attain/maintain an individual's home in a clean, sanitary, and safe condition and provide safe access and egress into/out of the home and within the home.

Code(s)

S5121 – Heavy Chore

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Eligibility Criteria

- **All the criteria noted above, section (1) Required Criteria for Flexible Benefits, must be met and documented in the Individualized Care Plan (ICP), along with;**
  1. Member qualifies for Flexible Benefit - Homemaker
  2. Documented summary of rationale for the timeframe requested.

  3. Chore services are limited to prevent eviction if renting and/or to mitigate unsanitary conditions
     a. Due to hoarding (member must (a) be diagnosed and/or (b) have evidence of hoarding) OR
     b. Due to preparation for insect or rodent extermination (If services are not the responsibility of the landlord)
  4. One of the following in-home (If contraindicated for 1.b, video or telephonic is allowed) assessments (a-c) is performed within 90 days prior to request and documents how the condition of member's home poses a significant risk to the health, safety and/or well-being of the member:
     a. LTSC Assessment; or
     b. Clinical Assessment; or
     c. Care Team member in home visit note such as, but not limited to, activity, care plan note, progress note.
  5. An unusual household task is required to be performed to attain/maintain member's home in a clean, sanitary, and safe condition and provide safe access and egress into/out of the home and within the home.
  6. Chore service is authorized in member's service plan.
     i. Member has a documented/confirmed medical, cognitive, or behavioral health related disability that impairs the member's ability to address or correct the environmental concerns independently; and
     ii. The care team has identified the condition or syndrome that underlies the disability, as well as the nature of the functional impairment; and
     iii. In the case of hoarding or comorbid Behavioral Health (BH) conditions, the care team consulted with BH and/or Care Team must be sought prior to requesting services if Chore services are being considered.
  7. The member's need exceeds the scope of work, or the intensity of physical effort provided by a homemaker service.
  8. Documented summary of rationale for the timeframe requested.

Guidelines

Authorization decisions must be made based on an in-person, in-home assessment of the member and the member's environment. The rationale for the length of time should be noted in the authorization request. The Care Team should consider whether homemaker or chore is most appropriate for the member.

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(C) HOME DELIVERED MEALS

For general required criteria, see (1) above.
For benefit limits and authorization timeframes, see reference table in (2) above.

Definition
Home-delivered meals are due to the absence of formal and informal supports and services. Home-delivered meals for members are usually limited to the provision of short-term support, but under infrequent situations, may be provided longer term. Home-delivered meals can be considered when a:

- Member requires meals post-discharge for an acute episode
- Member is unable to prepare their own meals

Code(s)
S5170
Eligibility Criteria

- **Commonwealth Care Alliance may grant exceptions to cover Home Delivered Meals in specific circumstances. All the criteria noted above, section (1) Required Criteria for Flexible Benefits, must be met and documented in the Individualized Care Plan (ICP), along with;**
    - The member lives in a private residence. Members living in facilities are not eligible; in such cases, the Care Team should coordinate with the facility to address the member's nutritional needs.

In addition to meeting the criteria above, the member's needs must fall into at least one of the three categories below

1. **Member requires meals post-discharge for an acute episode**
    - All of the below criteria must be met
        - The member must have a physical, cognitive, or behavioral- related condition that impairs the member's ability to perform at least one of the following IADLs:
            - Meal preparation
            - Grocery shopping
        - Homebound or leaves the home with difficulty as a result of the acute episode
        - Unable due to a physical or mental condition that hinders the member's ability to safely complete IADLs as a result of the acute episode

2. **Member is not able to prepare their own meals due to a physical, cognitive, or behavioral- related condition**
    - All of the below criteria must be met
        - The member must have a physical, cognitive, or behavioral- related condition that impairs the member's ability to perform at least one of the following IADLs:
            - Meal preparation
            - Grocery shopping
        - No other formal supports in the home for the member or their living companion, that provides the same service.
        - Homebound or leaves the home with difficulty
        - Unable due to a physical or mental condition that hinders the member's ability to safely complete IADLs on a weekly basis
            - Physical would include not being able stand for long periods of time and/or not able to bend over and/or fall risk

Guidelines

Home delivered meals do not include or comprise a full nutritional regimen and are limited. Multiple meals may be delivered at the same time provided proper storage is available in the home. Individuals must be unable to prepare food and not have alternative supports to meet the need. The specific guidelines/criteria for members requiring home delivered meals due to post-discharge or inability to prepare meals.

Whenever utilizing home delivered meals, care teams must plan to transition the member to a more sustainable plan for meals.

D. HOME/ ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

For general required criteria, see (1) above.
For benefit limits and authorization timeframes, see reference table in (2) above.

Definition

Home accessibility adaptations are covered only when the participant would be unable to reside in their own home without the accessibility adaptations and the adaptations enable the member to function with greater independence within the member's home and is limited to the following adaptions:

a. Basic ramps (For members who use a wheelchair)
b. Stair lifts (For members who use a wheelchair)
c. Grab bar installations (For members who are at risk for falls)
d. Air conditioner (1 5000-8000 BTU Unit) (For members who have a diagnosis of heart failure, asthma, or COPD)

Home accessibility adaptations may be covered for eligible members who are enrolled as participants under the Acquired Brain Injury (ABI)-N Waiver, Moving Forward Plan, (MFP)-RS Waiver or MFP-CL Waiver. Home accessibility adaptations may also be covered for participants who qualify for Transitional Assistance Services when adaptations are appropriate and necessary for the participant's discharge from a nursing facility or hospital and safe transition to the community.

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In order to participate as a provider of home accessibility adaptations under an HCBS waiver, a provider must be qualified to perform environmental and minor home adaptations in accordance with applicable state and local building codes and comply with any applicable registration or licensure requirements. Providers must also be under contract with Massachusetts Rehabilitation Commission (MRC) in accordance with its standards, requirements, policies, and procedures for the provision of home accessibility adaptations.

Code(s)
S5165

Eligibility Criteria
For All Requests, each of the following criteria must be met and documented in the Individualized Care Plan (ICP):

1. Home accessibility adaptation services are included in member's individualized plan of care; and
    a. Member participant would be unable to access and/or reside in their home without the adaptations; or
    b. The accessibility adaptations enable the participant to function with greater independence within the participant's home; or
    c. The accessibility adaptations eliminate or decrease the need for direct human assistance (e.g. personal care services); and
2. Adaptations are reasonable and necessary and least costly alternative and no community resources are available to support the member's need for the requested modification.
3. One of the following is documented:
    a. Proof of ownership
    b. If the member rents their residence, documentation must confirm that the requested modification is not the responsibility of the landlord under the lease agreement. For federally funded properties, landlords are typically required to make accessibility modifications. If the member rents and the modification is not covered by the landlord, written approval from the landlord is obtained before proceeding with the request.
4. The member has a need that aligns with the requested modification:
    a. Basic ramps: Member uses a wheelchair
    b. Stair lifts: Member uses a wheelchair
    c. Grab bar installations: Member is at risk of fall
    d. Air conditioner (1 5000-8000 BTU unit): If a member has a diagnosis of heart failure, asthma, or COPD

Provider must submit all the following documentation:

1. Standard Written Order (SWO) or Prescription for home accessibility adaptation(s) requested; and
2. A signed LMN based on an in-home accessibility assessment, completed by the assessing Physical Therapist (PT) or Occupational Therapist (OT); and
3. A detailed Home Accessibility Adaptation/Modification Plan, including:
    i. Detailed drawing of the Home Accessibility Adaptation/Modification; and
    ii. The service provider's quote regarding the cost of the of Home Accessibility Adaptation/Modification, including:
        a. a labor detail sheet; and
        b. the manufacturer's invoice for any products used under the HCPCS Code S5165 code; and

4. Home Accessibility Adaptation/Modifications - Acknowledgment and Agreement signed by homeowner(s); and
5. Proof of home ownership (deed or tax bill or mortgage statements)

NOTE: ALL requests for Home Accessibility Adaptations must include a completed Home Accessibility Adaptation Form.

Guidelines

a. This service includes two categories:
    a. Physical structural changes to the home, not already covered via Durable Medical Equipment (DME) and/or
    b. Accessibility adaptations.
b. Limited to the following services up to $15,000 per lifetime:
    a. Basic ramps (For members who use a wheelchair)
    b. Stair lifts (For members who use a wheelchair)
    c. Grab bar installations (For members who are at risk for falls)
        i. *Note: Not all grab bars require Home/ Environmental Accessibility Adaptions level of instillation*
    d. Air conditioner (1 5000-8000 BTU Unit) (For members who have a diagnosis of heart failure, asthma, or COPD)
c. The benefit does not include additional services that are needed to receive and/or install the service (e.g. electrical, wall repairs, painting, wall papering, etc.). The following will not be covered:
    a. Requests intended to bring a substandard dwelling up to minimum housing standards or to make general improvements (e.g., new carpeting, roof repairs, central air conditioning) that do not provide a direct medical or remedial benefit to the member are not eligible.
    b. Requests to add or expand the total square footage of the home.
    c. Modifications involving plumbing, electrical, or HVAC work.
    d. Adaptations which are required by law to be made by a landlord or other third-party.
    e. Transitional Services that are not necessary for the participant's safe transition to the community
    f. Home accessibility adaptations to a residential habilitation site, group home, or other provider-owned and - operated residential setting.
    g. The cost of maintenance, upkeep, or an improvement to a participant's place of residence.
    h. Home accessibility adaptations considered unsafe, unreasonable, or unnecessary for participant.
    i. Services furnished prior to the development of the individual service plan or not included in a participant's individual service plan.
    j. Services requested for the benefit of an individual other than the member participant who is eligible to receive such services and for whom such services are approved in the individual service plan
    k. The removal and/or remediation of existing home accessibility adaptations and/or any installed equipment if and when member is no longer in need of it.
    l. Accessibility adaptations NOT included in authorized Home Modification Plan.
    m. Purchase of extended service and/or maintenance contract(s).

5. HOMEMAKER

For general required criteria, see (1) above.
For benefit limits and authorization timeframes, see reference table in (2) above.

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Definition

Homemaker services are covered on a short-term or periodic basis when the individual who is regularly responsible for these activities is temporarily absent or unable to manage the home and care for the member and member is not eligible for any other covered MassHealth benefit. The Homemaker service includes assistance with: shopping, menu planning, laundry, and the performance of general household tasks such as meal preparation and routine household care provided by a qualified homemaker. A homemaker may be necessary on an interim basis when the individual regularly responsible for these activities for the member is temporarily absent or unable to manage the care for themselves or others in the home.

Code(s)

S5130, S5131

Eligibility Criteria

- **All the criteria noted above, section (1) Required Criteria for Flexible Benefits, must be met and documented in the Individualized Care Plan (ICP), along with;**
    1. The member resides in their own private residence. Members living in facilities are not eligible; in such cases, the Care Team should coordinate with the facility to address the member's needs.
    2. The member must have a physical, cognitive, or behavioral-related condition that impairs the member's ability to perform at least two (2) of the following IADLs:
        i. Meal preparation
        ii. Light Housework
        iii. Grocery shopping
        iv. Laundry
    3. Homebound or leaves the home with difficulty
    4. Unable due to a physical or mental condition that hinders the member's ability to safely complete IADLs on a weekly basis
        i. Physical would include not being able stand for long periods of time and/or not able to bend over and/or fall risk

Guidelines

a. Homemaker services are limited to 2 hours per week and would generally be approved as a benefit not to exceed 90 days. Members will require a reassessment of needs before another period can be authorized.
b. Homemaker services may be considered:
    a. as an alternative to Personal Care Assistant (PCA) services when the member's PCA is temporarily unavailable for homemaking tasks
    OR
    b. for members who are not eligible for PCA, have two or more IADL needs, and require homemaking support.
c. This service does not include minor home repairs, heavy household chores, or maintenance tasks such as washing floors, windows, or walls; tacking down loose rugs or tiles; or moving heavy furniture for safety purposes.

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6. LAUNDRY

For general required criteria, see (1) above.
For benefit limits and authorization timeframes, see reference table in (2) above.

Definition
Laundry includes pick up, washing, drying, folding, wrapping, and returning of laundry.. This service may not be provided at the same time when Homemaker services are being provided for the specific need of laundry assistance.

Code(s)
S5175

Eligibility Criteria

1. All the criteria noted above, section (1) Required Criteria for Flexible Benefits, must be met and documented in the member resides in their own private residence. Members living in facilities are not eligible; in such cases, the Care Team should coordinate with the facility to address the member's needs.
2. If the laundry is off-site, must be homebound or leaves the home with difficulty
3. Unable due to a physical or mental condition that hinders the member's ability to safely complete IADLs on a weekly basis
   ii. Physical would include not being able stand for long periods of time and/or not able to bend over and/or fall risk
4. Having such services will support the member's health status and ability to maintain integrated living in the community.
5. Any other documentation at CCA request, that includes, but is not limited to other nursing, medical or psychosocial evaluations or assessments, in order to complete its review and determination of prior authorization.

Guidelines

a. Laundry is authorized at one unit per week. One unit of Laundry equals one bag; and each bag of laundry equals 20 pounds or less. 2 bags of the member's laundry per week will be considered if the member has significant incontinence.
b. Laundry services are only provided to meet the needs of the member. Laundry for other household members cannot be included in bags.
c. Laundry services cannot be authorized as a financial support (to save the cost of supplies or laundromat fees).
d. Laundry services are not covered when the member receives another service that includes time for laundry tasks such as, but not limited to, Adult Foster Care, Group Adult Foster Care, Home Health Aide, Homemaker services, other Laundry service, Personal Care Attendant, Supportive Homecare Aide; care team must ensure that services are non-duplicative.

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7. NON-MEDICAL TRANSPORTATION

For general required criteria, see (1) above.
For benefit limits and authorization timeframes, see reference table in (2) above.

Definition
Service offered in order to enable member to gain access to CCA covered non-medical locations (pharmacy pick up, recovery meetings) and other community services, activities and resources, as specified by the service plan and no alternatives exist including but not limited to bus/train. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized. Members may not receive duplicative services from volunteer run transportation services.

Code(s)
N/A

Eligibility Criteria
- **For all requests, each of the following criteria must be met and documented in the Individualized Care Plan (ICP):**
  1. Documentation supports how non-medical transportation is required to promote self-management of documented chronic medical and behavioral condition(s) to maintain independent living, in alignment with member's ICP.
  2. No informal supports (family members, friends, neighbors, or community agencies) exist to assist the member. All informal support options must be explored and documented prior to authorization.
  3. Member does not have access to alternate modes of transportation (family, friends, local public transportation, e.g. bus, train etc.).

Guidelines
Commonwealth Care Alliance does not cover:
  a. Duplicative services (e.g., member's PCA care plan, Adult Day Health program includes/provides transportation services)
  b. Transportation to locations such as but not limited to casinos, bars, liquor stores and other destinations deemed not appropriate for coverage
  c. Transportation to/from cannabis dispensaries including medical and recreational purposes
  d. Out of state transportation for non-medical purposes, unless distance is less than closest in-state non-medical destination
  e. Transportation to child day-care centers and nurseries
  f. Transportation for non-CCA members including member's relatives and family members
  g. Transportation to work
  h. Transportation to veterinarian and pet care services
  i. Transportation of members who are elderly or disabled to adult day health programs, except when arranged by special contract with the Adult Day Health Program
  j. Transportation to schools, summer camps, and recreational programs (e.g., swimming classes)

k. Transportation of family members to visit a hospitalized or institutionalized member
l. Transportation to a medical facility or physician's office for the sole purpose of obtaining a medical recommendation for homemaker/chore services
m. Transportation to government-agency offices; unless trip is to social determinant destination
n. Transportation to visit a child in foster-care placement or in group-care placement
o. Medicare covered non-medical transportation

AUTHORIZATION:

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not signify that the service described by the code is a covered or non-covered health service. 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. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. 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).

REGULATORY NOTES:

Disclaimer

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.

RELATED REFERENCES:

2026 One Care Contract

ATTACHMENTS:

EXHIBIT A:	
EXHIBIT B	

REVISION LOG:

REVISION DATE	DESCRIPTION

Medical Necessity Guideline

APPROVALS:

Jeffrey Sedlack	Senior Medical Director Utilization Review and Medical Policy
CCA Clinical Lead	**Title**
	1/29/2026
Signature	**Date**
CCA Senior Operational Lead	**Title**
Signature	**Date**
CCA CMO or Designee	**Title**