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This guidance is designed to increase understanding of co-treatment, dispel common misconceptions regarding co-treatment, provide examples of the use of co-treatment for children enrolled in early intervention in Massachusetts, and aid Individualized Family Service Plan (IFSP) teams' clinical decision-making with respect to co-treatment.

This guidance incorporates longstanding policy and interpretations reflected in the Early Intervention (EI) Division's monitoring, Reimbursement Manual, and waiver request instructions to address common questions that the EI Division has received from parents, early intervention services program directors, and service coordinators. The EI Division is clarifying or expanding positions in the following areas:

- Definition and appropriate use of co-treatment
- Considerations for IFSP teams when discussing co-treatment
- Documentation for co-treatment
- Addressing distinct extraordinary circumstances

Definition of Co-treatment

Question 1: What is Co-treatment?
As used in this document and consistent with 101 CMR 349, the Early Intervention Operational Standards, the Reimbursement Manual for Early Intervention and Early Intensive Behavioral Intervention Services, the Waiver Request documents, and the Dear Colleague Letter from January 2026, "co-treatment" means two or more providers rendering the same service, designed to improve the child's developmental outcomes, to the same child at the same time. Co-treatments are limited to H2015 (i.e., a child visit at home, childcare, or in the community) and T1015 (i.e., a center-based individual visit).

Question 2: What are examples of co-treatment?
Co-treatment generally involves modeling intervention strategies across disciplines, coordinating interventions during the same visit, or addressing a complex clinical issue requiring simultaneous expertise. The following examples of co-treatment are offered to assist service coordinators in understanding possible ways in which co-treatment is used in practice: Examples of co-treatment are

- A child with complex feeding and oral-motor difficulties requires simultaneous intervention from both disciplines. The IFSP team determines that co-treatment is necessary because the Speech and Language Pathologist (SLP) is evaluating swallowing safety while the Occupational Therapist (OT) addresses positioning and adaptive seating that affect safe feeding. The interventions are interdependent and require simultaneous observation and adjustment. Separate visits would not achieve the same outcome because neither provider could adequately evaluate or modify the interaction between swallowing, positioning, and sensory regulation without the other's simultaneous expertise.
- A child is transitioning to a new adaptive mobility device. The IFSP team determines that co-treatment is necessary because the Physical Therapist (PT) addresses gait, weight-bearing, and mobility while the OT simultaneously adjusts positioning, seating, and functional use during everyday routines. Separate visits would not achieve the same outcome because the seating modifications directly influence mobility performance, requiring real-time collaboration and adjustment.
- A caregiver is learning strategies for mealtime. The IFSP team determines that co-treatment is necessary because the OT coaches environmental setup and positioning while the SLP coaches communication, oral-motor, and feeding strategies. Both practitioners actively coach the caregiver throughout the same routine. Separate visits would not achieve the same outcome because the caregiver benefits from seeing the strategies integrated during a single natural routine.
- A child with medical complexities requires coordinated intervention during a single routine. The IFSP team determines co-treatment is necessary because each provider contributes different expertise to safely support the child while simultaneously coaching the caregiver. Separate visits would not achieve the same outcome because the clinical issue requires integrated decision-making during the child's actual participation in the routine.
- A toddler with vision loss/blindness is developing orientation and tactual readiness skills by learning to identify things through texture and shape, basic concepts such as under/over, finger isolation skills, as well as listening skills to follow related directions while seated in an adapted chair. The IFSP team determines co-treatment with the specialty service vision provider is necessary so that the visual orientation and adaptive equipment can be incorporated into the OT's strategies for developing fine motor skills. Separate visits would not achieve the same outcome because consistent placement and instruction is necessary to support the child's orientation planning.
- A child who is Deaf/Hard of Hearing is learning auditory skills and sign language to attend to and understand family story/book reading. The team decides that co-treatment with the specialty service deaf and hard of hearing provider are necessary so that the P.T. can address and support the child's goals related to trunk support and page turning during this time. Separate visits would not achieve the same outcome because the providers and caregiver benefit from seeing communication and motor control strategies integrated during a single natural routine.

Question 3: How often can co-treatment occur?
Each child enrolled in Part C/early intervention may receive up to one co-treatment per calendar month. Up to four working hours are allowable for this monthly co-treatment, 2 hours per session per EI Specialist maximum. This is allowed for up to 3 different disciplined EI

specialists. This means that two providers could provide up to one, two-hour co-treatment monthly or three providers could provide up to one co-treatment monthly that adds up to 4 working hours.

Considerations for IFSP Teams When Discussing Co-treatment

Question 4: When might an IFSP team consider co-treatment appropriate to include in a child's services?
At its core, the child and their family or caregiver must derive the utmost benefit from the co-treatment. Co-treatment is appropriate only when the simultaneous active participation of two practitioners is necessary to achieve a clinically meaningful outcome that could not reasonably be achieved through separate visits. This means that each provider must contribute unique knowledge and interventions that directly support the child and family's progress toward IFSP outcomes.

Because IFSP services are individualized to the child, not all IFSP teams will determine that co-treatment is appropriate to include in a child's IFSP. Some children and families will derive greater benefit from separate visits. In other cases, there may not be a specific clinical reason requiring the simultaneous active participation of two or more providers. For children served by multiple types of providers, the services rendered by the different providers are distinct (e.g., H2015 and 97153) and do not meet the definition of co-treatment. Because co-treatments must not duplicate services or simply place two providers in the same visit, IFSP teams will not add co-treatment to a child's IFSP if it occurs due to scheduling preference or provider availability. In each of these scenarios, the IFSP team must add these services separately to the child's IFSP because they do not meet the definition of co-treatment.

Question 5: How can an IFSP team decide if co-treatment is necessary to achieve the goals of the IFSP?
The decision to include co-treatment on a child's IFSP must be individualized to the child and their family and there must be a clinical reason requiring the simultaneous active participation of two or more providers to meet the goals of the IFSP. The following questions are offered as a resource for IFSP Teams discussing co-treatment:

- Could separate visits reasonably achieve the same outcome for the child and their family?
- What important clinical outcome for the child would be lost if the services were provided in separate visits?
- What benefits would sequential visits provide to the child and their family?
- How will each provider actively participate and use their unique expertise and knowledge during a co-treatment?
- How will each provider address different conditions or unique aspects of the child's care during the co-treatment?
- What specific role will each provider have during the co-treatment?
- Is co-treatment necessary to achieve the outcomes on the IFSP?

Documentation for Co-treatment

Massachusetts Early Intervention Co-Treatment Guidance

Question 6: What happens after the IFSP Team agrees that co-treatment is necessary to achieve the goals of the IFSP?
Once an IFSP team has determined that co-treatment is necessary to achieve the goals of the child's IFSP, it is added as a service on the IFSP. Before the co-treatment can begin, the IFSP team must identify the service providers who will render the monthly co-treatment session and add them as separate service lines on the IFSP and obtain consent from the parent or legal guardian to implement the services on the IFSP. The first co-treatment, like all IFSP services, must occur within 30 days of the parent's consent to that service. Ongoing co-treatments must continue in accordance with the frequency and duration listed on the IFSP.

Question 7: What are the documentation requirements for a co-treatment visit?
Each provider participating in the co-treatment must complete a separate progress note in the child's record in EICS that includes the date of the co-treatment, the service type (i.e., H2015 or T1015), the duration of the co-treatment rendered, why co-treatment was clinically necessary, the provider's distinct role during the visit, the strategies modeled or coordinated during the co-treatment, and the name and discipline of the provider writing the progress note.

Addressing Distinct Extraordinary Circumstances

Question 8: What can a Service Coordinator do if there is a distinct extraordinary circumstance that necessitates deviation from these requirements?
Service coordinators may request an exception to the one co-treatment-per-month restriction by submitting a waiver request in EICS. These requests must provide specific and individualized clinical reasoning for why the simultaneous active participation of two or more providers more than once per month is necessary to meet the goals of the child's IFSP and why separate visits would not achieve the same outcome. These waivers must be submitted and approved by the Early Intervention Division in advance of the additional co-treatment being rendered.

Resources:

- Rates for Early Intervention Program Services, 101 CMR 349 (2026). https://www.mass.gov/regulations/101-CMR-34900-rates-for-early-intervention-program-services
- Department of Public Health (2022). *Early Intervention Operational Standards*. https://www.mass.gov/lists/early-intervention-policies
- Department of Public Health (2026). *Reimbursement Policy Manual for Early Intervention and Early Intensive Behavioral Intervention Services*, *version 12.*
- Department of Public Health (2024). *Waivers for Reimbursement Guidance Document.* https://www.mass.gov/info-details/early-intervention-billing-reimbursement